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Office of the Inspector General

REDACTED REPORT

This report is being released by the OIG 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, unless otherwise indicated, are fictitious.

FILE NO: 973893
MINORS: Derek Harper (DOB: 1/85)
Matt Humphrey (DOB: 1/90; DOD: 8/00)
Devon Foster (DOB: 4/90; DOD: 8/00)
Robert Foster (DOB: 6/92; DOD: 7/00)
SUBJECT: Death of Children

SUMMARY OF COMPLAINT

On July 19, 2000, the Office of the Inspector General (OIG) received notice of a fire in a Chicago foster home, in which three foster children were seriously injured. Investigators from the OIG were told that the children were not expected to recover from their injuries. Accordingly, the Inspector General opened this investigation.

SUMMARY OF INVESTIGATION

The case was brought before the OIG's Ethics Board, and has been the subject of discussion of the Task Force assembled to address the issue of wards accused of serious crimes. Moreover, at the urging of the Chicago Fire Department, the OIG hired engineers to conduct analyses of the mechanical and electrical systems.

Background on Children Involved in Incident

Harper/Humphrey Children
One of the victims of the fire in the Smith home was ten-year-old Matt Humphrey. Matt and his fifteen-year-old brother, Derek Harper, were placed in Josephine Smith's home on January 19, 2000. This home was a non-relative placement. In June 2000, Derek ran away from Ms.

Smith's home and was placed in another foster home.[1] Derek's foster placement was changed four days before the fire, after his foster parent brought him to Alpha Agency and told his caseworker that she could no longer control Derek. While the caseworker was discussing a new foster placement with her supervisor, Derek left the agency. The caseworker reported to police that he was missing.[2]

Matt, Derek, and their brother, Chris Harper, came to the attention of DCFS in 1992. At that time, their mother was indicated for inadequate supervision of Chris and Matt. On August 26, 1996, a subsequent report to the State Central Registry (SCR) alleged that Ms. Humphrey was abusing drugs and had again left the children without an adequate care plan. After that investigation, the case was opened for intact services. On June 25, 1997, a third call was made to SCR about the Humphrey family, alleging inadequate supervision and abandonment. The Department subsequently took custody of all three children on July 2, 1997; DCFS was granted guardianship of the children on February 2, 1999.[3]

Throughout their academic careers, Derek and Matt both showed promise. Although Derek has experienced some behavior problems in school, he told OIG investigators that he "understands what he needs to do," and has begun to set goals for his future. Derek told the OIG investigator that he is currently on the honor roll at his school and he works part-time.

Foster Children

Devon and Robert Foster both lived in the Smith home and died of injuries they sustained in the fire. Devon and Robert were placed in the Smith home in July 2000. Their worker placed them in this home for "respite."[4] It was not anticipated that they would remain in the home for a lengthy period of time.

Devon and Robert's family came to the attention of DCFS on January 4, 1990, when their eldest brother was brought to the hospital for medical neglect. In addition to Devon and Robert, their mother, Ms. Simon, had four other children. Ms. Simon did not have appropriate housing for her children, and the record reveals that she suffered from severe depression, and had congestive heart failure. She was collecting disability benefits. She and her children often lived with her sisters and her sisters' children in apartments that were not able to reasonably accommodate all. Although the Department offered services and Norman funds to Ms. Simon, she could not care for the children, and DCFS consequently placed the children in foster homes.[5]

[1] Josephine Smith told OIG investigators that she had announced that she wanted all the foster children in her home to undergo drug tests in June. The next day, Derek left the home.
[2] Derek is currently placed in a residential facility.
[3] DCFS workers placed Chris with his natural father, Derek Harper, Sr. and his father's wife. However, Derek and Matt's natural fathers were not involved in their lives, and no relative placement was available. Derek Harper, Sr. is not Derek's father, although Derek carries his name.
[4] This was actually an emergency placement, as this report will discuss. A licensing complaint investigation conducted after the fire revealed that the children's former foster parent surrendered her foster care license and the children therefore had to be moved from her home.
[5] Given Ms. Simon's disabilities, a payee should probably have been appointed to manage her benefits and assist her in securing adequate housing. The Department could also have explored having a portion of her benefits sent directly from Social Security to her landlord.

Their early lives were chaotic, and records show that the children struggled in school because they were seldom in attendance. However, foster care had given the children some stability and Robert had begun to show improvements in school. Devon had exhibited some behavioral problems in school and at home, but had been provided therapy to address those problems. According to Devon's therapeutic record, Devon caused a fire in the apartment where he lived with his natural family when he was approximately six years old. Devon's mother, Ms. Simon, told the OIG investigator that the fire in the apartment set by Devon was relatively small. Ms. Simon declined to go into further detail, but said that the majority of damage to the apartment resulted from water used by the Chicago Fire Department. This was the only fire-setting incident reported in Devon's therapeutic file.

Unbeknownst to the therapeutic team working with Devon and his family, Illinois was the first state to develop a fire intervention program where trained firefighters interview children who are believed to have fire-setting problems. The intervention program uses measurements developed by the Federal Emergency Management Association (FEMA). Children are rated on a three-point scale of "Little concern," "Moderate concern," and "Extreme concern." Depending on their needs, children are offered counseling and/or education services.

Alpha Agency's Licensure of Josephine Smith's Home

Ms. Josephine Smith applied for a foster care license with Alpha Agency. After some delay, caused by some structural conditions with the home and getting medicals completed, Alpha Agency granted Ms. Smith this license in February 1998. Derek Harper, Matt Humphrey, and Devon and Robert Foster would eventually all be placed in her home.

Josephine Smith is a single mother of seven children, ranging in ages from eight to 27. Ms. Smith's oldest child had two children of her own. Ms. Smith had three sons. Another of Ms. Smith's daughters also had two children. Ms. Smith reported on her foster care application that none of these children resided in her home. However, Ms. Smith also reported that two of her children, a fifteen-year-old daughter and seven-year-old son, resided with her.[6] The daughter's medical record indicated that she had developmental delays.

On the forms she submitted as part of her foster care application, Ms. Smith wrote that she worked from 11:00 p.m. until 7:30 a.m. as a machine operator at a local company. She had worked there for seven years and had an annual total household income of $32,000.

As part of the licensing application, Josephine Smith also completed a Child Supervision Plan. On this form, she indicated that she left home at 10:30 p.m. and returned at 8:00 a.m., but she also worked overtime hours. During her absence, her oldest daughter would come to her house and supervise the foster children. This plan would be in effect during the summer and holidays and in case of illness.

[6] During an interview with OIG investigators, Derek Harper stated that five Smith relatives lived in the home: three children of Josephine Smith and two of her grandchildren.

Included in the licensing packet was a fire protection-evacuation plan completed by Josephine Smith. On this form, she affirmed that her home had at least one working fire alarm on each level. She indicated that the primary evacuation route was to exit out the front doorway, crawling. The alternate evacuation plan was for the children to leave the home using the back door or windows. She stated that the person responsible for the children was "the older person." This was the entire extent of protection-evacuation plan. Ms. Smith told OIG investigators that she rehearsed this plan with her children while Alpha Agency licensing representative Joe Gandy was present, but not since that time.

Alpha Agency licensing representative Joe Gandy completed the original home study evaluation for Ms. Smith's home on January 11, 1998. He determined her home was out of compliance with DCFS standards and she should not receive a foster home license. In his home study, Mr. Gandy described Ms. Smith's home as follows:

> Ms. Smith moved into her large wood-frame home approximately six months ago. The home is located in the [*neighborhood name redacted*] community and is centrally situated as to the community's many resources. Her particular block, however, has been a hot bed for gang-related drug sales and violence in recent years. The 6-bedroom home has a large backyard and a two-car garage. The fencing, however, is gapped and leaning. The property does not appear to have enjoyed proper maintenance as both porches suffer water rot and the home needs external cosmetic work….
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> This worker's tour of the home began in the attic which houses [three] bedrooms – one of which was inaccessible due to a nailed door. The two available rooms were quite large but required plaster and painting care as well as removal of extended nail heads from the floorboards. The stairwell leading downward to the second level was also in need of patching and paint. Water stains from the ceiling evidenced a recent leakage. The second floor, which included Ms. [Smith's] room as well as an adjoining room used by [*name redacted*], was more acceptable….
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> The main floor was relatively well furnished and tidy. The living room included a large screen TV and nicely organized furnishing….The kitchen contained two fully stocked refrigerators and a table setting for four. Scampering mice were seen [as] well as a few roaches despite the kitchen's apparent cleanliness. The source of this "minor" infestation Smith well have been the approximately six inches of sewage water that settled on the basement floor.

Mr. Gandy noted that Ms. Smith appeared to be warm-hearted and sincere. However, he did not believe that Ms. Smith's home complied with licensing standards at the time of the home study and he recommended that the home not be licensed at this time. Ms. Smith told Alpha Agency she would be able to bring her home into compliance within 30 days of the denial.

Before the 30 days expired, a committee convened to review Mr. Gandy's recommendation in the home study evaluation.[7] According to Alpha Agency's Division Director, this committee convenes once a month to review home study recommendations. The home study is the only document reviewed at these meetings, and the goal is for parties to reach a consensus regarding the home study. Generally, the committee questions the licensing representative to make sure that he or she did not miss any important issues and to ensure that the recommendation is reasonable. It appears that Mr. Gandy's recommendations were upheld.

Thirteen days after Mr. Gandy's home check and after the committee meeting, Susan Mitchell, Alpha Agency licensing coordinator, visited Ms. Smith's home for a follow-up review. Ms. Mitchell said she was usually the person to do a follow-up check when a licensure application was denied. Ms. Mitchell told the OIG investigator that Ms. Smith had repaired all items of concern to Mr. Gandy. The Addendum stated:

> Ms. Smith was extremely eager to show Ms. Mitchell that the suggested repairs had been completed. The water in the basement was completely gone and the floor was dry. There were no rings around the walls to show that water had been there. Plaster repairs were completed and repainted. Ms. Smith has signed a contract to have new front and back porches done in the spring.
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> The visit occurred on a Saturday morning and Ms. Smith's children were all at the home eating a late breakfast together. The atmosphere was warm and caring….
>
> Ms. Smith's daughter comes to the home every evening by 7:00 p.m. She spends the night along with her 5-year-old child. She usually stays until noon the next day. Ms. Smith works some weekends….

There was no mention in the addendum of the presence of rodents or roaches, the protruding nail heads in the bedroom or cause of the water damage on the second floor. Although Ms. Mitchell did not note whether she observed the presence of vermin in the home, when she was asked whether the infestation problem had been eradicated in such a short time, she replied, "I didn't see any mice or roaches in the home during my visit."

On February 23, 1998, Susan Mitchell sent Ms. Smith a letter indicating that her application for foster home licensure had been approved. The Smith home was licensed for four foster children.

In neither home study was there mention of the presence of smoke detectors. DCFS's Licensing Compliance Record does not contain any prompt for workers to check for workable smoke detectors. It is therefore unclear whether either Mr. Gandy or Ms. Mitchell ever checked for smoke detectors in the home.

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[7] Alpha Agency's in-house procedures require a committee to convene to review licensing recommendations. Persons sitting on this committee include: the Licensing supervisor; the Division Director; Donald Clay, a pastor of a local church; the licensing representative; an adoptive parent; relevant case manager; and relevant case managing supervisor.

According to the record, Joe Gandy executed the first of two licensing compliance record checks on Ms. Smith's home in January of 1998. Ms. Mitchell did the second compliance record check on July 12, 2000, just six days before the fire in Ms. Smith's home. In each year, both licensing staff members failed to check the line verifying "fire hazards". In fact, out of the entire licensing record, this is the only item not checked for both years. When asked specifically whether she checked for fire hazards or saw smoke detectors during the July 12th check, Ms. Mitchell replied, "I did not specifically look for fire hazards, but do not recall seeing any…and I cannot recall whether I saw any smoke detectors." Ms. Mitchell admitted that she rushed through the compliance check because Ms. Smith had to leave the house. In addition, she conceded that she does not know how to check a smoke detector to see if it is operational.

During Ms. Mitchell's licensing compliance check, she amended the capacity for foster children in Ms. Smith's home from four to five because she wanted to place Devon and Robert Foster in Ms. Smith's home.[8] According to Ms. Mitchell, it was only supposed to have been respite care, as someone would soon be able to take Devon, Robert, and their sister to keep all three together. The Licensing Compliance Record indicated that Ms. Mitchell inspected the premises on that date, including checking the children's rooms. She noted that she checked the kitchen and dining rooms, and that the home was in reasonable compliance with licensing standards. She recommended that a license be issued, indicating that the Smith home should have a capacity of five children. She signed this form, certifying that she had performed a license study in full for the applicant.

Placement of the Foster Children in the Smith Home

The Foster children were placed in the Smith home on July 12, 2000. However, the supervising case manager from Alpha Agency did not call the placement clearance desk until approximately six days later, on the 18th or 20th of July 2000. A clearance desk representative said that the supervisor reported that only one of Ms. Smith's biological children resided in her home. However, when Alpha Agency employees dropped off the Foster boys, Ms. Smith claimed that two of her biological children were home.[9] In any event, the clearance desk representative denied the placement for reasons that appear to suggest that he or she needed more information from Alpha Agency.[10]

The OIG investigator asked Ms. Mitchell to explain how she concluded that Ms. Smith could receive Robert *and* Devon Foster in her house, without having requested an Expanded Capacity License. She responded, "Devon and Derek were away at camp for two weeks, and [her seven

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[8] At this time, the children under 18 years of age residing in the Smith home included: Matt Humphrey (10), Devon and Wendell Humphrey (16 year-old twins), Ms. Smith's 15-year-old daughter, and Ms. Smith's seven year-old son. Devon and Wendell Humphrey were not related to Matt Humphrey.

[9] This Alpha Agency employee is no longer an employee of Alpha Agency and was unavailable to comment as to how he concluded only one of Ms. Smith's biological children was residing with her.

[10] The clearance desk representative could only review limited information on her screens with regard to the OIG investigator's inquiries. The information she could see led her to believe that the representative who actually handled the Alpha Agency employee's call probably did not have enough information to provide him with a clearance. She could not say with certainty.

year old son] was with his father, which left only [her 15 year old daughter] and Matt."[11] Ms. Smith, however, denied that her seven year-old son has ever *resided* with his father, although he visits him from time to time and happened to be visiting on the night of the fire.

The Caretaker on the Evening of the Fire

The children had several caretakers on the evening of the fire, and there was general confusion over who was an appropriate caretaker of Ms. Smith's children in her absence. On July 18, the night of the fire, Josephine Smith left her home for work at 10:00 p.m. At the time she left, there were approximately eleven people in her home, as her family was planning a reunion.[12] Ms. Smith had arranged for her next-door neighbor to care for the children. At 2:00 that morning, however, the neighbor went to her own home to begin getting ready to leave for her job. The neighbor left Josephine Smith's nineteen-year-old son, and his eighteen-year-old girlfriend, the neighbor's daughter, in charge of the numerous children in the home that evening.

In approximately September 1999, Ms. Mitchell made a notation on Ms. Smith's licensing monitoring record stating that her neighbor would spend the night from 11 p.m. until 7:30 a.m. Workers in the Office of Child Development (OCD) confirmed that both the neighbor and Ms. Smith's niece were being paid as alternate childcare providers at different times.[13]

Instead, Alpha Agency's records reflect that from March 1998, Ms. Smith's 27-year-old daughter would be the caregiver in Ms. Smith's absence. The recorded alternate care plan was that the daughter would come to her mother's house by 7:00 p.m., spend the night, and stay until noon the next day. The daughter would also bring her five-year-old daughter with her. However, Ms. Smith claimed that her daughter rarely kept the children and was not the daycare provider being paid. The OCD confirmed that Ms. Smith's 27-year-old daughter was not and had never been paid for the care of Ms. Smith's foster children.[14]

There is no record of a background check on Ms. Smith's daughter as a day care provider in the licensing file. Ms. Mitchell's supervisor claimed Ms. Mitchell had the responsibility to do a background check on the recorded alternate caregiver before children were placed in a foster home. Lisa Hamilton, case manager for the foster children in the Smith home, said she also assumed that the licensing representative had done the check for Ms. Smith's daughter. However, Ms. Mitchell was under the impression that it was a caseworker's responsibility to

[11] Derek Harper also confirmed that Ms. Smith's seven-year-old son had moved to live with his father.
[12] In the home at the time of the fire were four of Josephine Smith's children, ages 13, 15, 17and 19; two of her grandchildren; her son's girlfriend, and a relative of the Smith family. Foster children Devon Foster (10), Robert Foster (8), and Matt Humphrey (10) were also present.
[13] According to the OCD, Ms. Smith's niece was paid for two separate days of childcare, and the neighbor was paid for two other days of childcare. According to Ms. Smith, in all other instances, Ms. Smith paid the neighbor herself. Ms. Mitchell said that she had never heard of Ms. Smith's niece.
[14] After the fire, Agencies and Institutions/Licensing conducted an investigation of Alpha Agency. This investigation revealed that Ms. Smith's daughter was indeed one of the persons scheduled to care for the children the night of the fire. Derek Harper confirmed that Ms. Smith's daughter was the primary alternate caregiver. The OIG investigators are unsure of whether the neighbor was the regularly scheduled caregiver on the night of the fire. This would be problematic, as she left the home at 2:00 a.m.

check out an alternate caregiver's criminal history. She further explained that, typically, a caseworker would fill out a form called the *Foster Parent Application for Employment Related Day Care* (hereafter "Child Care Application") and that the OCD would conduct a search pursuant to the request for child care payment. A Program Planner II at the OCD denied that background checks were the function of her office.

Had a background check on Ms. Smith's daughter been conducted, it would have revealed that she was convicted on 2 separate cocaine charges in January of 1998, a few months before Ms. Smith was licensed. Workers at the OCD said that they would not have approved an application for Ms. Smith's daughter to be Ms. Smith's childcare provider with her history.

The Fire[15]

On the evening of the fire, all of the occupants of the home went to bed at approximately 3:00 a.m. Ms. Smith's fifteen-year-old daughter slept downstairs on a couch. The fifteen-year-old allegedly heard glass break, but went back to sleep. Shortly thereafter, she smelled smoke and got up to see what had happened. At that time, she discovered that there was fire in the middle of the kitchen floor. The fire and smoke were intense, so she ran out the front door of the home. Another young girl, who was sleeping on the first floor with the fifteen-year-old daughter also fled the home.

According to the fire investigators, when Ms. Smith's fifteen-year-old daughter opened the front door and let more oxygen in, she unwittingly aided the fire's rapid growth. When firefighters arrived at the home, they found several people on the overhanging roof of the front porch. They rescued two males and two females from the roof. Another of Ms. Smith's daughters had dropped her two children from the front porch to a neighbor. The survivors alerted firefighters that the foster children were still in the home, sleeping in the back bedroom.

Three firefighters entered the burning building with a hose. They made their way to the second floor back bedroom, where they found the three boys. One child was found face down, with his head in a closet under a pile of clothing. Another child was found face down, on the floor near the first child. The third child was found on the bottom bunk bed, with his face down on the bed. The firefighters carried the children out of the home away from the fire. One child was injured when the staircase collapsed as the firefighter descended.

The heaviest fire damage occurred to the dining room and kitchen areas, which were next to each other on the first floor of the home. One fire report noted that the dining room displayed the most severe charring at the ceiling and floor levels. The foster children's bedroom was located above the dining room. The route of the fire was described in fire reports as follows:

> The [fire marshal] noted extensive heavy charring in the living room in the southwest corner of the structure and the kitchen area. The fire vented through a bay window on the south exterior wall and lapped into the second floor bedroom and window. The fire on the first floor traveled down a hallway between the

[15] The account of the fire is taken from several reports completed by the Chicago Fire Department.

kitchen and the front door and traveled vertically and horizontally up the interior stairwell.

The Cause of the Fire

Investigative teams from the Chicago Fire Department's Office of Fire Investigation studied the debris of the home and interviewed witnesses in an effort to determine the cause of the fire. The fire marshals made a number of findings.

Fire marshals failed to find any smoke detectors in the home. While one fire marshal noted that there was evidence of "mounting hardware" for a smoke detector, it appears that there were no smoke detectors, working or otherwise, in the home.[16]

Fire marshals identified several potential causes of the fire. One fire marshal immediately noticed that the control on the oven was found to be in the "on" position, indicating that the oven or the burner on the stove had been left on.

One fire marshal also identified the overuse/misuse of an extension cord supplying one of the refrigerators as a potential problem. According to the Fire Marshal, the extension cord "wound around the flexible gas connector and wadded together along the north wall of the kitchen."

Smith's neighbor (not the same neighbor as had been babysitting) also told one of the investigating fire marshals that she had seen Derek Harper about fifteen minutes before the fire outside of the home. Derek had been picked up by police on the evening of the fire because he had run away from his new foster home and a warrant had been issued for his return.[17] One theory about the cause of the fire, however, was that Derek had thrown something into the home to start the fire. The Department hired an attorney to protect Derek from potential criminal charges. Derek's attorney refused to allow Derek to speak with the police any further.

As the investigative team continued through the fire debris in the kitchen, it discovered an open container with an odor that was similar to that of lighter fluid. After the team raised the issue with Josephine Smith, she informed them that she did not store such a container in her kitchen. Ms. Smith indicated that her neighbor used charcoal lighter fluid to grill, but stored the lighter fluid in a storage shed. Fire marshals described the storage shed as follows:

> The storage shed is essentially the covered rear entry, below grade, staircase that leads to the basement of the subject structure (west end). There is a cement ledge

[16] When the Fire Department interviewed Ms. Smith's 15-year-old daughter a second time, she said that she had not heard a smoke detector when she got up and saw smoke and flames in the kitchen.

[17] On July 18, 2000, Lisa Hamilton filed an Unusual Incident Report in which she reported Derek Harper's status as a runaway ward. Ms. Hamilton noted that she had been called and asked to pick up the minor from the police station. Ms. Hamilton said that the police had picked up Derek at the scene of the fire because he was a missing person. Derek was brought to the police station for questioning about the fire, but was released to the custody of Alpha Agency. Ms. Hamilton noted that Derek was very upset about the fire, because his sibling was a victim of the fire. Derek left the agency without the knowledge of Alpha Agency staff and did not return. Ms. Hamilton therefore again listed him as a missing person with the police.

> that Ms. Smith identified as the supposed location of the charcoal lighter fluid; however, the [reporting fire marshal] could not find the charcoal lighter fluid as described above.

Another of Ms. Smith's neighbors told the investigative team that he had grilled a turkey the weekend before the fire. He confirmed Ms. Smith's assertions that he placed the container in the stairwell leading to the basement and "that is where he last remembers seeing it."

After the Chicago Fire Department concluded its investigation, the Fire Marshal submitted a closing report. In this report, the Fire Marshal concluded that there were electrical code violations in the home. He noted that there was an open service panel and overuse of extension cords. He indicated that an inspection of the appliances in the kitchen was conducted. In the kitchen were two microwaves, two refrigerators, and a gas piloted oven/range. He noted that there was heavy fire damage to the wall behind the area where the range had stood. He stated that he had been able to identify "the following possible ignition sources: the pilot light of the gas range and the electrical heat energy produced by an extension cord."

His summary and conclusion read as follows:

> It is the opinion of the [reporting fire marshal] that the fire originated in the kitchen area, north section. In this area, the [reporting fire marshal] has eliminated all other possible ignition sources and has identified the remaining possible ignition sources as: the overuse/misuse of an extension cord supplying a refrigerator, and a recently installed gas piloted range.

At the urging of the Chicago Fire Department's Office of Fire Investigation, the Inspector General contracted with mechanical and electrical forensic engineers to develop a more conclusive finding. The mechanical engineer ruled out a recently installed gas stove range as the cause of the fire. On June 30, 2000, Ms. Smith had purchased a new range/oven. This new oven was installed shortly thereafter. The electrical engineer, however, suspected that the person who installed the range might have damaged one of the extension cords.

The Inspector General received the report concerning the electrical engineering analysis of the Smith home on Smith 31, 2001.[18] The engineer concluded that the most likely cause of the fire was the extension cord running to one of the refrigerators in the kitchen. The engineer's report reads in relevant part:

> An examination of the extension cord conductor remains identified that it was approximately 15 feet in length….Along the length of one of the cord conductors there was a deformed conductor point….This type of metal deformation is the result of an electrical arc event. Two conductors exhibited damage indicative of electrical arcing activity….

[18] The engineer's report was delayed because the engineers would not release the final report until all witnesses had been interviewed.

> It is my opinion that the damage found is from a damaged point in the extension cord. This type of electrical-related damage is typically created from a damaged conductor. An electrical current would normally run through the cord conductors to supply the refrigerator load. If the cord conductors are damaged, a hot spot can develop at the damaged point of the conductor. With electrical current flowing this can create a point of overheating along the conductor. The point of overheating continues to increase in temperature, eventually opening the circuit and creating an electrical arc. This is known as a parting arc. A parting arc can definitely release energy. A parting arc is a recognized event that can provide an ignition source to start a fire.
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> The exact routing of the cord is unknown. Since the refrigerator was just west of the range/oven, it is suspected that the cord may have been damaged when the range/oven was replaced or if other activity was occurring in proximity to the range/oven.

Licensing Complaints

After the fire, two licensing complaints were initiated. A supervisor at Alpha Agency received the first complaint on July 20, 2000 and assigned it to Susan Mitchell to investigate. In completing the investigation of this complaint, Ms. Mitchell interviewed Josephine Smith and her family members.[19] She also indicated that she reviewed a number of documents during the course of the investigation, including the Chicago Fire Incident Report.[20]

While recounting the substance of the interviews she conducted, Ms. Mitchell noted that four of the Smith relatives recalled hearing an alarm sound in the Smith home that alerted them to the fire.[21] Josephine Smith also reported that there were smoke detectors in the house located above the doorway in the kitchen, and at the top of the stairs on the second and third floors. However, Smith's 18 year-old son did not report hearing an alarm. He said only that he heard people shouting.

Attached to the Licensing Complaint was the report of the Chicago Fire Department, which Ms. Mitchell indicated that she had reviewed. This report noted that there were no smoke detectors present in the home.

Nonetheless, Ms. Mitchell concluded that the foster home had not violated any licensing standards. Ms. Mitchell wrote, "It does not appear that the foster parent failed to comply with the licensing standards. It should also be noted that, when asked to describe what happened the

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[19] The Licensing Complaint Investigation Contact Summary indicated that she spoke with Josephine Smith, her 15 year-old daughter, her granddaughter's aunt, her 17 year-old daughter, her 27 year-old daughter, her 19 year-old son, her 18 year old son, and her neighbor and the children's caretaker.

[20] Ms. Mitchell reviewed the Fire Protection-Evacuation Plan from the Licensing File; the Child Supervision Plan from the Licensing File; the CANTS report; and the Chicago Fire Incident Report.

[21] The relatives who reported hearing an alarm were Josephine Smith's two daughters, her 19 year-old son, and her granddaughter's aunt. At the time of the fire, the 15 year-old daughter and the aunt were on the first floor, the 19 year-old-son was on the second floor, and Ms. Smith's other daughter was on the third floor.

night of the fire, four people reported hearing an alarm or beeping sound. Josephine reports that there was a smoke detector on each floor. Alpha Agency has not received a final report on the cause of the fire."

Licensing-Agencies and Institutions (Licensing) conducted an investigation of Alpha Agency contemporaneously with Alpha Agency's investigation of the Smith home. Licensing discovered that there were twelve people in the home at the time of the fire. According to DCFS Licensing notes, Ms. Smith stated:

> [A] 15 year old former ward who previously resided in her home was observed at 2:00 a.m. by a neighbor. The neighbor asked the minor what was he doing in the yard. The youth replied nothing, and moved on. Shortly after this occurrence the neighbor told Ms. Smith [she] heard glass shattering. It was stated that this minor threw a [mulatov] cocktail through the back porch window which started the fire. The minor was observed in the crowd watching the fire.

Ms. Smith also told DCFS Licensing that the minor had wanted to come into her home to pick up his clothing, but she had refused to allow him to have his clothes.[22] Ms. Smith stated that the minor spent a great deal of time in the area, but she did not believe that he started the fire. Ms. Smith also stated that there was confusion over her supervision plan. She said that, unbeknownst to her, her 27 year-old daughter, the alternate caregiver, had left the home and had left Josephine Smith's nineteen-year-old son and his eighteen-year-old deaf girlfriend in charge.

DCFS Licensing also spoke with the CEO of Alpha Agency; a supervisor; Lisa Hamilton, the Alpha Agency case manager; and the APT liaison for Alpha Agency. The Licensing staff reviewed a number of Alpha Agency files and other documents.

Licensing found that Alpha Agency had violated two licensing standards. First, Alpha Agency violated licensing standard 401.250 because the Josephine Smith foster home exceeded its license capacity by one child. The licensing representative noted that the foster children had been moved into the home on July 7, but the amended capacity did not occur until July 12.

The Licensing representative also found that Alpha Agency violated standard 401.420(h) because the agency did not submit paperwork in a timely fashion. Licensing found that Alpha Agency had not submitted the 906 on time, had not obtained approval from the Placement Clearance Desk and had not issued a timely Juvenile Arrest Warrant. Licensing stated the following:

> "Derek [Harper] was placed in the home of Josephine Smith on 01/19/00. He was then transferred to [another] licensed foster parent's home, on 06/22/00. The agency completed the 906 form reflecting placement movement on 07/24/00. This minor is a habitual runaway. There were no UIRs submitted on this minor,

[22] The OIG investigator called Derek's worker to verify that Derek was not in need of clothing. The worker stated that he did not think there was a problem, but he would verify that there was no need to issue a clothing voucher. Derek told OIG investigators that he did not need new clothing.

> to the Department, within the compliance time. The only JAW issued on the minor was completed 07/17/00.
>
> The Foster brothers placed in this home on 07/07/00 were not approved by the Placement Clearance Desk. [An] official from the Desk indicated she received two calls for placement at this home 07/18/00 and 07/20/00. The Placement Clearance Desk denied both request[s]."

The Licensing worker recommended that Licensing-Agencies and Institutions conduct a random monitoring visit and review 25% of the agency's files for foster homes and children. Also, foster home visits would be initiated.[23]

On September 18, 2000, representatives from Licensing met with Alpha Agency staff members that were involved in this case. Alpha Agency staff present at this meeting were the CEO of Alpha Agency; Division Director of Alpha Agency; Alpha Agency Licensing Coordinator; and the Alpha Agency Case Manager.

During this meeting, Licensing staff addressed problems they saw with Alpha Agency's handling of the Smith home. A DCFS Licensing manager first voiced her concern that the Placement Clearance Desk had not authorized the placement of the children in the home. The CEO of Alpha Agency admitted that the Placement Clearance Desk had not been called until after the fire. The DCFS licensing manager then asked about the submission of the 906 form. The CEO of Alpha Agency stated that the agency had not known that the 906 had not been completed in a timely fashion. After the fire, however, the 906 was submitted and reflected the appropriate days for payment.

Alpha Agency officials acknowledged that the agency had not completed any study when it tried to increase Ms. Smith's capacity for foster children placement. Alpha Agency staff members stated that they did not believe that the home was over capacity because two of the children were at camp and one of Ms. Smith's children had gone to live with his father. The Foster children had only been placed in the home for temporary respite care.

Alpha Agency officials noted during this meeting that they felt that the fire evacuation plan included in the Licensing file was adequate. Alpha Agency staff contended that DCFS Licensing officials had reviewed their files numerous times and had never pointed out that the evacuation plan was inadequate. Alpha Agency staff was unaware that there were bars on the back doors and windows of the Smith home. According to the notes, however, Alpha Agency officials believed "this did not hinder the children getting out of this home."[24] Alpha Agency officials

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[23] As of May 24, this review had not taken place. After speaking with DCFS Licensing staff, a DCFS licensing worker indicated that the review had been re-assigned to her, and she would begin the review on June 18. She indicated that a Licensing manager would be personally reviewing several of the files, as she has particular concerns.

[24] The newly assigned licensing worker told OIG investigators that she had seen security bars on the windows of the bedroom in which the foster children slept. The pictures of the home after the fire do not clearly show whether the security bars were present, and they were not mentioned in the reports of any of the other professionals investigating

could not confirm that the children placed in the home for respite were aware of the evacuation plan.

The DCFS Licensing manager then questioned Alpha Agency staff about Derek's status. The supervisory review notes state that Alpha Agency officials asserted that Derek Harper was never missing for more than 24 hours while in Ms. Smith's care. When the minor was missing, he was often located at his grandmother's home within the 24-hour time period. Alpha Agency staff reported that no Unusual Incident Reports or Juvenile Arrest Warrants had been issued on the child. They said that July 14, 2000 was the only time that officials were aware that there might be a reason to issue a JAW.

DCFS Licensing staff discovered that Derek had raised concerns about the foster home regarding rats, standing water in the basement and doors off hinges. The Alpha Agency case manager stated that she had documented the concerns Derek had raised in her case notes and had gone to the home to check on it, but no licensing complaint had been initiated because "it was not a complaint[,] it was a concern." The case manager reported that the other children in the home had refuted the allegations.

Alpha Agency officials believed that the Smith family "went beyond the call of duty to ensure that an adult was in the home with the foster children during the absence of the identified care giver and her back-up." The DCFS Licensing manager asked if Alpha Agency officials felt that Ms. Smith's nineteen-year-old son and his young girlfriend were adequate back-up. The agency staff responded that, while this was not the agreed-upon plan, it was a back-up plan. They also stated that they could not be held accountable for a plan of which they had no knowledge.

DCP report

After the fire, various reporters called the State Central Registry (SCR) to report that the foster children had been injured. Subsequent calls reported the deaths of the children.

The case was assigned to Child Protective Investigator (CPI) Frank Torman. He named Josephine Smith and Derek Harper as caretakers. However, the investigator seemed to focus his investigation on Derek Harper. The allegations investigated by CPI Torman were #1, death due to abuse, and #5, burns due to abuse. On the CFS 1440, the investigator unfounded both allegations. Torman wrote, "The fire was ruled 'undetermined' by the Chicago Police-Bomb and Arson Division. There is no [currently] credible evidence that the fire, which caused the death of the wards, was intentionally started." His supervisor added to this note, "There were no incendiary devices found, and Derek denied involvement. At this point, DCFS has no evidence that Derek started the fire." The supervisor appeared to have added the word "currently" to Torman's note.[25]

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the cause of this fire. Moreover, because of the path of the fire noted by the Chicago Fire Department, the children could not have exited through the window, regardless of whether the security bars were present or not.

[25] According to Torman and his new supervisor, his former supervisor is no longer with the Department.

After allegation #5, Torman wrote, "As noted above, there is no credible evidence that the fire was intentionally started by Derek or anyone else." His supervisor added at the end of this note, "At this point." His supervisor also wrote, "Derek has denied the arson, but police have not been able to pursue speaking to him. If he is ever charged, a new report must be made to the hotline."

CPI Torman told OIG investigators that he made a mistake when investigating this case. He indicated that, after speaking with representatives of Alpha Agency, he was under the impression that there was no issue of whether the children had been adequately supervised on the evening in question. He acknowledged, however, that he had not checked the Alternate Care Plan in Ms. Smith's licensing file, had not documented any conversations with Alpha Agency staff concerning supervision, and had not verified Alpha Agency's claims in any way.

Torman said that, upon receiving the CANTS report, he and his supervisor contacted Alpha Agency's CEO. Based on this conversation, he and his supervisor concluded that the focus of the investigation would be to look at whether Derek Harper had started the fire.

Alpha Agency Newsletter

Susan Mitchell's supervisor was not aware that her supervisee had approached her husband [Mitchell's husband], the Chief Executive Officer of Alpha Agency, regarding Josephine Smith's financial condition. Without consulting with her supervisor or Ms. Smith, Susan Mitchell wrote a paragraph soliciting funds on Ms. Smith's behalf, and placed this solicitation in Alpha Agency's newsletter which was distributed to other foster parents.

ANALYSIS[26]

Licensing Errors

Inadequacies in Rules and Procedures

Rules and procedures for licensing foster homes do not adequately address fire safety issues. Rules and procedures do not require that foster homes have smoke detectors, although licensing day care rules require operable smoke detectors. In addition, licensing day care rules require that day care homes comply with all municipal codes, including fire safety. The only reference that

[26] This is the second time the Inspector General has seen a case where there was a fire in a home with no smoke detectors where five or more children lived. These cases show that it is not uncommon for young children to experiment with fire, when they are bored or, sometimes, curious. Therefore, the Department should train workers to know about these alternative programs. For example, programs administered through Illinois Youth Fire Starters Association assess the risk a child is, and provides mental health and educational resources to the child and his or her family. This program is free of charge and available throughout the state. The program is also willing to develop training programs for DCFS and POS licensing supervisors to teach them about fire safety issues, such as identifying fire hazards and checking smoke detectors to ensure they are operable.

rules make to foster homes complying with municipal codes is that foster homes comply with municipal codes regarding maintenance of pets.

Smoke detectors contribute significantly in reducing fire deaths. National Fire Incident Reporting System (NFIRS-1994) data show that only 19.2 % of fire deaths occurred in homes known to have operational smoke detectors.[27] One reason that smoke detectors are so effective in saving lives is that a high proportion of fatal fires occur at night, as in this case, and smoke detectors alert residents early enough that they have a better chance of escaping.[28] Statistics suggest that the presence of smoke detectors in this home Smith have saved three children's lives.

In addition, the DCFS Licensing Compliance Record form and monitoring record had no prompts to direct the workers to check for smoke detectors and to check their condition. Procedures give no direction to workers on what constitutes a fire hazard and gives no prompt for checking the condition of smoke detectors in the home.[29] It is unconscionable that DCFS and private agencies would place children in a foster home without ensuring that they would be in a home with working smoke detectors.

Procedures also do not adequately instruct licensing workers about completing effective fire protection/evacuation plans. Procedures should be amended to require licensing workers to ensure that the designated exits in fire protection/evacuation plans are unobstructed. This is not an unreasonable requirement, and is consistent with other licensing rules. For example, Rule 402.9 says that basements and attics can only be licensed if there is assurance that the windows are unobstructed so they can be used as exits in the event of an emergency. This evidences a concern about giving children a means of escape in the event of an emergency.

Many fire safety authorities have very specific requirements for effective evacuation plans. For example, according to the City of Chicago Fire Department, a reasonable fire evacuation plan should include a graphic lay out of the residence and two escape routes per room, especially bedrooms. DCFS Procedures should be amended to instruct licensing workers that, when they are helping a foster parent develop a fire protection/evacuation plan, they draw detailed floor plans that are reasonable representations of each floor of the home; they identify two escape routes for each bedroom represented on the floor plan; they designate one specific meeting place; and they identify a specific person by name, and an alternative person, who will help the younger and older members of a household out of the home. Each time a licensing representative completes a monitoring visit of the foster home, the fire protection/evacuation plan should be reviewed with all members of the family, and the licensing representative should verify on the Licensing Monitoring Record that fire evacuation plans had been reviewed.

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[27] United States Fire Administration, 1990, p. 78. All information on smoke detectors from NFIRS refers to cases where their presence and operability was reported only.

[28] Socioeconomic factors and the incidence of fire, p. 15, the Federal Emergency Management Agency, United States Fire Administration, and National Fire Data Center.

29 While the Department is reviewing the presence of smoke detectors, the Inspector General sees no reason why workers do not also check for the presence of carbon monoxide detectors.

Moreover, whenever the Placement Clearance Desk authorizes the placement of a child in a foster home, the worker who brings the child to the home on the initial visit should take this opportunity to review the fire evacuation plan with the child. The residents of the home should participate in two "fire drills," one practicing evacuation of the home relying on the primary exits and another that assumes that primary exits have been blocked. The worker conducting the drills should note in the child's record and in the licensing file that the drills had been conducted, how they went, and any unusual events that occurred.

Errors of the Licensing Worker

Many eyes have examined this case, and one conclusion is evident: Susan Mitchell did not properly complete her duties as the licensing coordinator of Alpha Agency. Her explanations for her failures are varied. However, whether Susan Mitchell ignored rules and procedures, or was simply ignorant of the requirements set forth in rules and procedures, she did not discharge her responsibility to ensure that the Smith home was a safe placement for these foster children, and her employment should be terminated.

During OIG interviews, Susan Mitchell sometimes acknowledged that she had no knowledge of certain rules and procedures. For example, she admitted to OIG investigators that she did not know what an Expanded Capacity License was. However, as the licensing coordinator for Alpha Agency, it would be reasonable to expect that she would know and understand the requirements for licensing a foster home. If a Alpha Agency staff person had a question about whether a placement in a particular foster home was appropriate, for instance, that worker should be able to rely on Ms. Mitchell to provide them with correct responses to licensing questions.

When the Smith home was licensed, it was licensed for four children. The total capacity of the home would include both biological children and foster children, where none of the children required specialized care. Rule 402.15. At the beginning of July 2000, it could be presumed that two of Ms. Smith's children lived in her home, as her original licensing application stated, and as Ms. Smith herself stated. Ms. Smith's licensing file indicated that her daughter experienced developmental delays. Rule 402.15(a) says that, where a child has developmental needs that require specialized care, even if that child is a biological child, then those needs should to be taken into account in determining the capacity of the home. There is no indication in the file to show that Ms. Mitchell gave any consideration to whether Ms. Smith's daughter's disability should be factored into the total number of foster children that Ms. Smith's home could accommodate.

In addition to the two biological children, three foster children were living in the Smith home at the beginning of July: Matt Humphrey, and Devon and Wendell Humphrey.[30] This means that the Smith home already exceeded its capacity of four children at that time.[31] Ms. Mitchell then decided to increase the capacity of the Smith home to five children and place the Foster children in the home because they were in need of "respite" care. Clearly, this was an erroneous decision.

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[30] Derek Harper had been placed in the Smith home in January 2000, but had been moved to another placement on June 22, 2000.

[31] OIG investigators have repeatedly re-calculated these numbers and believe that they are correct. However, the Inspector General's findings do not agree with the findings of Licensing-Agencies and Institutions.

The placement of the Foster children in the Smith home caused the home to exceed its capacity of children. Placing the Foster children in the home meant that there were seven children under age 18 that lived in a home licensed to accept five children: Ms. Smith's 15 year-old daughter, her 7 year-old-son, Matt Humphrey, Desmond Humphrey, Wendell Humphrey, Robert Foster and Devon Foster. In her calculations concerning the number of children that could be moved to the home, Ms. Mitchell wrongfully took into consideration factors such as two of the foster children in the home being away at camp and one of the natural children visiting his father for a short period. Apparently, Ms. Mitchell considered children who were temporarily away from the home as not residing in the home.

When calculating the capacity of a home, a licensing representative should not take into consideration factors such as children being temporarily away from the home because there could be no guarantee that they will stay away. For example, one or both of the twin foster children away at camp during the fire could have been sent home for any number of reasons. To rely on such variables would make capacity decisions tenuous, at best, and create pervasive inconsistency.[32]

Moreover, the Foster children needed an "emergency" placement and were not in need of "respite" placement. Rule 402 defines "respite" care as a temporary placement that should not exceed 30 days. Respite care is provided in order to give full-time caretakers rest that is needed to prevent placement disruption. The Foster brothers were removed from the previous foster placement because that foster mother decided to give up her foster care license. The children were not returning to that home.

In addition to capacity issues, Ms. Mitchell also failed to take any steps to ensure that the children would be safe in the unlikely event that a fire occurred. Ms. Smith told OIG investigators that the only one who ever rehearsed the evacuation plan with her was Joe Gandy, during the initial licensing stage when she had no foster children in her home. The six foster children that were subsequently placed in her home had no opportunity to rehearse an evacuation plan. Rule 402.8(g) instructs licensing workers that fire evacuation plans should be discussed and routinely rehearsed with the children. When Ms. Mitchell placed the Foster children in the Smith home on July 12, 2000, she had an obligation to rehearse the fire protection/evacuation plan at that point.

On the day that Ms. Mitchell completed the licensing compliance check to increase capacity in the foster home so that she could place the Foster brothers in that home, Ms. Smith was in a hurry to get Ms. Mitchell to leave. Ms. Mitchell told OIG investigators that she rushed through the check of the home to accommodate Ms. Smith. Careful attention to detail was sacrificed because of the need to complete a hurried licensing compliance check. Ms. Mitchell had an obligation to do a thorough and detailed check to ensure that the home was in such a condition that the children would be safe, including ensuring that the home had working smoke detectors and was free of fire hazards.

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[32] Ms. Mitchell's erroneous calculations of the number of children in Ms. Smith's home means she would not have requested an Expanded Capacity License even if she had known that she should have.

Because Ms. Mitchell was rushed during this monitoring visit that took place six days before the fire, she told OIG investigators that she could not recall whether she checked for smoke detectors in the home. In fact, there were none in the home. The Fire Marshal of the Office of Fire Inspections stated that none of the members of the household he interviewed claimed to have heard an alarm during the fire. In addition, while the fire department found the *mountings* for smoke detectors, no detectors, nor any portion of them, were ever found.

It was a critical error that no one checked for smoke detectors in this wood frame home. Although the rules do not technically require compliance with municipal codes, Ms. Mitchell erred when she failed to check for smoke detectors. While rules and procedures might not require smoke detectors in foster homes, common sense would prompt one to question whether there were smoke detectors.[33] Not only did common sense fail to prompt her, Ms. Mitchell told OIG investigators that she did not know how to check a smoke detector to see if it was in working condition. She showed no initiative in carrying out her responsibilities. The Inspector General would hope that the Board of Directors of Alpha Agency would acknowledge that this was a critical function of a licensing coordinator.

As the licensing coordinator, Ms. Mitchell also erred in that she did not inquire into the background of the identified alternate caregiver. Alpha Agency staff thought it was Ms. Mitchell's responsibility to do a background check. Alpha Agency staff members were aware that Josephine Smith was employed in a full-time position and that her hours were from 11:00 p.m. until 7:00 a.m. Ms. Smith provided this information when she first submitted her application for a foster care license. Pursuant to Rule 402.11(d), Alpha Agency personnel were required to approve the alternate caregiver appointed by Ms. Smith before the children were placed in the Smith home. Ms. Smith indicated that her 27 year-old daughter would provide care for the children in her absence. This daughter had two separate convictions on cocaine charges two months before Ms. Smith's foster care license was approved. These charges would have barred the daughter from being authorized as a caregiver and Alpha Agency did not discharge its responsibility to the children when it failed to conduct this background check.

Ms. Smith also stated that her 27 year-old daughter and her daughter would arrive at her home in the early evening and leave the home at noon the next day. The daughter functioned as a live-in babysitter, bringing her child with her to the Smith home. The reality is that this 27 year-old daughter would have been responsible for nine children: six foster children, her two siblings, and her own daughter.[34] If the daughter had been present on the evening of the fire, she would have had the responsibility for ensuring that all these children were safe.

After the fire, Susan Mitchell was assigned to investigate whether the Smith home violated any licensing provisions. Ms. Mitchell unsubstantiated the investigation, after an inadequate investigation, and concluded that there must have been smoke detectors in the home.

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[33] In many other investigations, the Inspector General has noted that other licensing representatives note the presence of smoke detectors as complying with "general requirements."
[34] There were conflicting reports concerning whether Ms. Smith's daughter had been at the Smith home earlier that evening, but had left early to go to work and left the neighbor in charge.

Ms. Mitchell wrote, "It does not appear that the foster parent failed to comply with the licensing standards. It should also be noted that when asked to describe what happened the night of the fire, four people reported hearing an alarm or beeping sound. Josephine reports that there was a smoke detector on each floor. Alpha Agency has not received a *final* report on the cause of the fire." (Emphasis added.)

Attached to the report was a copy of the Chicago Fire Department's initial report. In this report, the fire department noted that no smoke detectors were found in the home.[35] Ms. Mitchell noted in her investigation summary that she had reviewed the Chicago Fire Incident Report. It is not clear what value Ms. Mitchell placed on this report, or how she resolved the inconsistency between the witness statements she recorded and the unbiased report of the fire department. Ms. Mitchell was simply negligent in failing to take this report into account when completing her investigation.

Where the worker who has licensed a foster home is subsequently assigned to investigate a licensing complaint against that same home, a conflict of interest can result. This case provides an example of how this conflict can arise. One *possible* explanation for Ms. Mitchell's findings is that she had an interest in seeing that Ms. Smith was not found to have engaged in municipal code violations. After all, Ms. Mitchell had just checked the Smith home six days before the fire but had possibly overlooked the fact that no smoke detectors were present.

DCP Investigation

The morning of the fire, two reporters called the State Central Registry to report that three children were injured. The substance of the CANTS summaries was similar; both reporters noted that there had been a fire in a foster home and that three foster children had been taken to area hospitals. The reports both indicated that another foster child had been picked up by the police for questioning about the fire. There was little other information contained in either report.

Frank Torman, the CPI assigned to this case, and his supervisor both concluded that the proper focus of this investigation was whether Derek Harper, the foster child that had been picked up by the police, had started the fire. His entire investigation focused on whether sufficient evidence could be gathered to support these allegations. Because this was his focus, he negligently failed to inquire into whether the foster parent, the children's caretaker, had done anything that would have put the children at risk.

The Abused and Neglected Child Reporting Act, 325 ILCS 5/1 et seq., (ANCRA) defines "abused child" as a child "whose parent or immediate family member, or any person responsible for the child's welfare, or any individual residing in the same house as the child, or a paramour of the child's parent" causes some harm to the child. 325 ILCS 5/3. DCFS Rule 300 similarly

[35] In two prior reports, Ms. Smith's 15-year-old daughter made no reference to hearing a smoke alarm.

defines the appropriate focus of a DCP investigation into possible abuse. Therefore, based on these definitions, it was proper for Mr. Torman to inquire into whether Derek had caused any harm to his brother, Matt, as Derek was an immediate family member to at least one of the victims.

While this investigation into Derek's behavior on the night of the fire might be defensible because of possible interpretations of the statutory language, it certainly cannot be considered appropriate. Derek was fifteen years old and was not a caretaker of his brother. He had had no contact with his brother for approximately one month. If, in fact, there was sufficient evidence to show that he might have started the fire, this was a delinquency matter, and not an abuse matter. To conclude that Derek could appropriately be thought to be responsible for abusing these children stretches the purpose of ANCRA. Confusion over how to handle child-on-child abuse has been addressed in *DePuy v. McDonald*, No. 97-C4199 (N.D. Ill. March 30, 2001) and in other investigations of the OIG.

Because of his focus on Derek, Mr. Torman failed to address the relevant issue of whether there was adequate supervision of the children on the night of the fire. Josephine Smith was also a person responsible for the child's welfare and her behavior should also have been subjected to some inquiry by Mr. Torman. At a minimum, Mr. Torman should have inquired into whether the children were adequately supervised in the Smith home on the night of the fire, whether there was a proper evacuation plan for the children and whether appropriate safety precautions had been taken, such as having working smoke detectors and clear exits from each room. His investigation did not take into consideration any of these factors. Mr. Torman's supervisor is no longer with the Department, and therefore her actions cannot be addressed. Mr. Torman should be counseled about this error.

Additional Considerations

Derek Harper was in the crowd that watched the Smith house burn. A neighbor of the Smith family claimed that she had seen Derek running through the Smith backyard right before the fire started. The CANTS report taken by SCR stated that paramedics claimed that a former foster child with psychological problems may have started the fire. Reports of the Chicago Fire Department stated that Derek might have started the fire. Derek was picked up by the police, questioned and released. Given the nature of the rumors, the DCFS guardian hired an attorney to represent Derek.[36]

This attorney prevented Derek from giving any information to the police or the child protective investigator looking into the incident. While advising the client to refuse to give any information might have been ethically required of the attorney, this advice delayed the proceedings in this case, and prolonged the scrutiny under which Derek was placed. For example, the electrical engineer ultimately determined that the cause of the fire was most likely a defective extension cord running to the refrigerator. However, the fire report and the findings of DCP were both

[36] Unfortunately, when the OIG recently spoke with the attorney regarding some of these rumors, he indicated that he erroneously believed that Derek's brother had been killed on the night of the fire.

delayed for approximately nine months because the parties were waiting to interview Derek before reaching any final conclusions.

Child welfare is a multi-disciplinary field. Lawyers, judges, mental health professionals, doctors, and social workers all come together with one purpose - to safeguard the interests of the children who are served by the system. However, each of these professionals is bound by his or her own set of professional ethical obligations. For the system to work, for all professionals to discharge the responsibilities they have agreed to shoulder in the battle to help these children, each professional must learn to respect the other's professional obligations.

This can be difficult, especially when those ethical obligations clash. Determining the proper course of action, weighing and balancing the ethics of, for example, the legal profession versus the field of social work, can often feel like it requires the knowledge of Solomon. Because this issue deserves lengthy discourse and requires debate, the Inspector General has assembled a Task Force that will work to resolve these conflicts. This Task Force is made up of representatives from the Cook County Public Defenders Office, State's Attorney's Office, Office of the Cook County Public Guardian, the DCFS Guardian's Office, DCFS Legal, the American Bar Association Children and the Law Center, and various ecumenical groups. The results of the discussions of the Task Force will be the subject of a future report to the Director.

Potential Conflicts of Interest

This investigation is one of several conducted by the OIG in which nepotism has been found in a private agency.[37] Within DCFS, nepotism is prohibited by Section 3.15 of the Employee Handbook which states that "(n)o employee shall participate in any way in the hiring, supervision, or evaluation of any immediate relative." Furthermore, no DCFS employee Smith be in a position of administrative authority over a family member where he or she has input into "any discipline, time off, salary, (or) other issue which might create the impression of preferential treatment."

DCFS has not imposed a corresponding prohibition of nepotism within private agencies with which it has purchase of service contracts. Consequently, although if Susan Mitchell and her husband were DCFS employees at that time, his direct administrative authority over her as CEO of Alpha Agency would not be permitted, their status as private agency administrator and employee placed them outside the scope of Section 3.15.

Recently, the Council on Accreditation for Child Welfare Agencies released new standards for accreditation which include a requirement that "the organization's personnel policies prohibit nepotism and specify: (a) conditions for employing and retaining relatives of governing body or advisory board members; (b) conditions for employing and retaining relatives of employees; and (c) protection against favoritism in supervision and promotion." Standard G4.2.03. The COA's accompanying interpretation of this standard explicitly bars work situations like the Mitchells'. It states: "This standard does permit the hiring of relatives, *provided that relatives do not work within the same hierarchy of supervision.*" (Emphasis supplied.)

[37] See, for example, OIG File Nos. 97-4078, 01-0348.

This case is a good illustration of the pitfalls of allowing family members to have supervisory or administrative authority over each other in the child welfare field. DCFS and its contracting agencies exercise a public trust to keep children safe from abuse and neglect. It is especially important that the public have confidence that decisions made by child welfare professionals are competent and objective. When family members have supervisory authority over each other, that confidence is undermined because of the reasonable suspicion that relatives' work will be evaluated leniently.

In this case Susan Mitchell failed to adequately check for smoke detectors and fire hazards in her brief inspection tour of Ms. Smith's home and nevertheless approved the home for licensing. Other errors by Ms. Mitchell included: (1) allowing more than six children to reside in the home without filing an Expanded Capacity License form, (2) failing to do a background check on Ms. Smith's adult daughter who was listed as the day care provider in the licensing file, and (3) having minimum information in the supervision plan while allowing a foster parent to use a child care plan that was not recorded. These oversights were not caught or corrected by her supervisor and Ms. Mitchell was not disciplined for her negligence. This may be the result of poor supervision by her immediate supervisor. However, it is also reasonable to suspect that the supervisor was reluctant to closely examine or criticize the work of Ms. Mitchell because of her marriage to the CEO of Alpha Agency and the supervisor's ultimate boss. As the COA standard puts it, the Mitchells were in the same hierarchy of supervision. The incident that occurred with respect to Susan Mitchell consulting with her husband about soliciting funds for Ms. Smith without consulting her supervisor is evidence of these problems.

Ms. Mitchell herself admitted that she sometimes failed to consult with her supervisor after her supervisor sent a letter to her complaining about poor communication. It is difficult to know for certain whether Ms. Mitchell's laxity about reporting to her immediate superior would have existed were she not the wife of the CEO, but this behavior again creates at least the appearance of impropriety. Nepotism is problematic precisely because it leads to speculation that related employees are relying on favoritism to avoid the accountability that objective job performance evaluations would bring.

RECOMMENDATIONS

1. *This recommendation addresses personnel issues and has been redacted.*
2. ANCRA and the corresponding DCFS rules should be amended to qualify the words "immediate family member."
3. The contracts of private agencies should reflect the anti-nepotism rule that relatives may not work within the same hierarchy of supervision in an agency.
4. DCFS should work with the Jim Plunket [*name unchanged*] of Illinois Youth Fire Safety Association to develop a training program for licensing supervisors to increase their knowledge of fire safety. At a minimum, licensing workers should know about identifying fire hazards and testing smoke detectors. DCFS should choose twelve licensing supervisors, from both DCFS and private agencies, to participate in a pilot training program conducted by Jim Plunket. Mr. Plunket is willing to conduct the

training during the summer of 2001, and has offered to supply the room for the training at no cost to DCFS.

5. All licensing workers should be trained on how to test whether smoke detectors are in working condition.
6. DCFS Rules should be amended to reflect that foster homes should comply with all state and municipal codes regarding fire safety.
7. DCFS procedures should be amended as follows:

   *Procedures should require that the Office of Child Development should be required to review LEADS checks on alternate childcare providers, in addition to CANTS checks, before any payment to the childcare provider is issued. OCD can either review the print-out of the LEADS check completed by the licensing worker, or should have authorization to conduct its own LEADS checks if there is no completed LEADS check or if there is a need to verify information contained in a suspicious LEADS check.

   *Procedures should reflect effective fire protection/evacuation plans. Such plans should incorporate suggestions of the State Fire Marshal and the fire department of a major municipality, such as identifying two escape routes from each bedroom, and should include floor plans of the home that clearly delineate those escape routes.

   *Procedures should require at least two fire drills by foster parents each year.

   *Procedures should require that licensing workers review evacuation plans and conduct fire drills whenever the Placement Clearance Desk authorizes the placement of a child in a foster home.
8. To avoid conflict of interest, where there is death or serious injury, workers who license a foster home should not be the same worker assigned to conduct a licensing investigation complaint against that home.
9. DCFS should revise its Licensing Compliance Record form (form CFS-590) to require that workers note whether foster homes have working smoke detectors, and to show the dates on which the licensing worker checked the smoke detector.
10. Alpha Agency Board of Directors should receive a copy of this report.
11. DCFS should send out a memo as soon as possible requesting that all DCFS and private agency licensing workers should immediately check for the presence of smoke detectors and to check whether the smoke detectors are in working condition. The Inspector General has confidence that all foster parents would cooperate with this request.
12. The Board of Directors of Alpha Agency should ask Circle Urban Ministries [*name unchanged*] to assist its foster care licensing division with identifying fire hazards and licensing foster homes.