OFFICE OF THE INSPECTOR GENERAL

ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

ANNUAL REPORT TO THE GOVERNOR
&
THE GENERAL ASSEMBLY

JANUARY 2023

ANN MCINTYRE
ACTING INSPECTOR GENERAL

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

January 1, 2023

To the Governor and Members of the General Assembly:

I respectfully submit the 2023 Annual Report of the Office of the Inspector General for the Illinois Department of Children and Family Services.

Created in 1993, following the tragic death of a three-year-old child whose family had a history of involvement with the Department, the Office of the Inspector General is committed to reforming and strengthening the child welfare system through independent, comprehensive investigations. Through the vision and wisdom of the first Inspector General, who served in the role for over 25 years, the Office was founded upon a multi-disciplinary, collaborative approach to investigations in which integrity and independence are paramount. I am honored to have been appointed this past June to serve as the Acting Inspector General of the Illinois Department of Children and Family Services. Throughout my 27 years with the Office in the roles of investigator, supervising attorney, and chief legal counsel, I have been committed to the mission of this Office. During this transition of leadership and moving forward, this Office will continue to hold the Department, as well as individual employees, supervisors, administrators, and contractors, accountable for systemic deficiencies and instances of misconduct.

This year, the OIG identified a systemic pattern of child protection investigations in which there were significant delays in making initial contact with alleged child victims of abuse or neglect. In these cases, the Department failed to fulfill an essential responsibility in protecting children. (See Death and Serious Injury Investigation 13 and the full report in Appendix A.) Additionally, several investigations conducted this year highlight the critical need for communication and collaboration among multiple entities. The Department, while charged with protecting children, cannot alone ensure the well-being of our most vulnerable children and families. (See Death and Serious Injury Investigations 1 and 10.)

Pursuant to Illinois administrative rules, in FY 2022, the Office of the Inspector General conducted an investigatory review of prior Department involvement in 171 child death cases. (See Child Death Report, p. 45.) Each and every one of these child deaths is heartbreaking, and the circumstances surrounding some are tragic and even horrific. When considering the number of cases reviewed by the OIG, it is critical to note that a review of the Department's prior involvement with the deceased child's family does not necessarily indicate wrongdoing or failures on the part of the Department or the child's parents. Rather, these investigations are an opportunity for a thorough case examination to identify practice errors and missed opportunities for intervention on behalf of children and families. The investigatory review aims to inform recommendations to improve child welfare practice. Our Office is founded upon a fundamental belief that the life of each child is a story that deserves to be told. As public servants, we must learn from their stories.

As we enter 2023, it is with solemn reflection that we pause to remember the tragic death one year ago of Deidre Silas, a child protection investigator murdered while responding to a call of child endangerment in a home. We also remember child protection investigator Pamela Knight, who died in 2017 following a brutal beating while attempting to remove an endangered child from his father. The Department and all

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government leaders have a duty to support and protect front-line child welfare workers who are dedicated to ensuring the safety of children and providing services to families.

I am grateful to the Governor for the opportunity to serve as the Acting Inspector General of the Department of Children and Family Services and it is with heartfelt appreciation that I recognize my team for their unwavering commitment to the mission of this Office and the children and families of Illinois.

Respectfully,

Ann McIntyre
Acting Inspector General

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 the 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 the 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 (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.

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

INVESTIGATIVE PROCESS

The 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.

In FY 2022, OIG reviewed 709 Requests for Investigation and conducted 7,239 searches for criminal background information. Requests for Investigation and notices of deaths or serious injuries are screened to determine whether the facts alleged suggest possible misconduct by a Department employee, private agency employee, foster parent, service provider, or identify a need for systemic change. If an allegation is accepted for investigation, OIG will conduct a full investigation pursuant to 89 Ill. Admin. Code 430. 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 refer complaints 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, when appropriate.

ADMINISTRATIVE RULES

Rules of the Office of the Inspector General are published in the Illinois Register at 89 Ill. Admin. Code 430. The Rules govern intake and investigations of complaints from the general public, child deaths or serious injuries, and allegations of misconduct. Rules pertaining to employee licensure action are found at 89 Ill. Admin. Code 412.

CONFIDENTIALITY

A complainant to the OIG, or anyone providing information, may request that their identity be kept confidential. 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. Redacted reports are also shared with other entities that interact with, or are involved in, the child welfare system.

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 ensuring the integrity of records, OIG investigators may impound files by immediately securing and retrieving original records.

INVESTIGATION CATEGORIES

DEATH AND SERIOUS INJURY INVESTIGATIONS

According to DCFS Rule 430, the Inspector General investigates deaths or serious injuries in foster homes, child welfare institutions, independent living programs and other facilities licensed by the Department, as well as deaths or serious injuries when there was an open child welfare service case or child protection investigation by the Department within the preceding 12 months. The Inspector General is an *ex officio* member of the Child Death Review Team Executive Council. When the Illinois State Central Register (SCR) receives a report of child death or serious injury, a Critical Event Report is generated. OIG reviews the Critical Event Report and other computer databases to determine whether the death or serious injury meets the OIG criteria for case opening. OIG opens a case for a child death or serious injury when the family has had prior involvement with the Department, or its contracted agencies, within one year of the death or serious injury. 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 2022:

FY 2022 CHILD DEATH CASES REVIEWED	
INVESTIGATORY REVIEWS OF RECORDS	**134**
FULL INVESTIGATIONS *	**37**
CHILD DEATHS IN FY 2022 MEETING OIG CRITERIA FOR REVIEW	**171**

* 13 deaths were included in a systemic issue report

Summaries of death investigations where a full investigative report was submitted to the DCFS Director in FY 2022 are included in the Investigations Section of this Report. Later in the same section, there are summaries of all child deaths reviewed by OIG in FY 2022.

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.

CHILD WELFARE EMPLOYEE LICENSURE (CWEL) INVESTIGATIONS

In 2000, the General Assembly mandated that the Department institute a system for licensing direct service child welfare employees. The CWEL system permits centralized credentialing and monitoring of all persons providing direct child welfare services, whether 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 CWEL 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 CWELs.

A committee composed of representatives of OIG, the CWEL 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.

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 CWEL Board. The CWEL Board makes the final decision regarding licensure action.

In FY 2022, 41 cases were referred to OIG for CWEL investigations.

FY 2022 CWEL Investigation Dispositions	
Pending Investigation	**12**
License Relinquished	**8**
Monitored Child Protection Investigation of Licensee	**18**
Closed	**3**
FY 2022 CWEL Investigation Referrals Received	**41**

Criminal Background Investigation and Law Enforcement Liaison

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)). Because 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) OIG, unlike the Department, has access to criminal history outside of Illinois within limits set by the National Crime Prevention and Privacy Act. The Law Enforcement Agencies Data System (LEADS), as dictated by state and federal law, cannot be used to conduct background checks for employment or licensing purposes. The Illinois Administrative Code forbids use of the LEADS network and LEADS data for personal purposes. OIG provides technical assistance to the Department and private agencies in performing and assessing out of state criminal history inquiries for the purpose of child safety in emergency placement. OIG answers case requests for criminal background information from LEADS. Each case may involve multiple law enforcement database searches and may involve requests on multiple persons. Though LEADS results may be used immediately, fingerprint checks are required for confirmation.

In addition to child protection investigator and caseworker requests, when the Placement Clearance Desk is considering a non-licensed home for placement and the Illinois LEADS contains an arrest which may pose a safety threat to a child, but does not include 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.

In FY 2022, OIG's six LEADS operators conducted 7,239 searches for criminal background information.

The OIG serves as the primary liaison between the Department and the Illinois State Police. 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 investigations, as requested. 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

In FY 2022, OIG received 105 referrals for investigation from the Office of the Executive Inspector General (OEIG). After preliminary review, a referral may be closed, opened for further investigation, or transferred for further review by Department management, the Office of Affirmative Action, Labor Relations, or the Advocacy Office for Children and Families.

Preliminary review is the initial review completed upon receipt from the OEIG. Referrals that are closed at the preliminary stage include referrals that do not meet OIG criteria for investigation, referrals with insufficient identifying information and referrals previously submitted by a different source and opened through general intake. The Office of the Inspector General closed 52 referrals at the preliminary stage, 46% of which closed because they did not meet criteria for investigation, and the remaining 54% of which closed because the allegations had been addressed in a prior complaint received through general intake. The Office of the Inspector General returned seven referrals to the OEIG because of lack of jurisdiction.

Investigatory reviews occur after the intake staff determine the referral meets the Office of the Inspector General criteria for investigation. An investigatory review includes obtaining and reviewing relevant case record information. Fifty-one investigations were closed at the investigatory review stage after it was determined no further action was warranted.

Two OEIG referrals are pending full investigation.

FY 2022 Referrals from OEIG	
Preliminary Review	**52**
Investigatory Review	**51**
Full Investigation Pending	**2**
FY 2022 OEIG Referrals	**105**

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 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 may revise the report accordingly.

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.

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.

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. Ideally, discipline should have an accountability component as well as a constructive or didactic one. It should educate an employee on matters related to their 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 they have simply violated an arbitrary rule with no rationale behind it. 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 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.

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
- 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 following chart summarizes OIG's response to calls received in FY 2022.

CALLS TO OIG HOTLINE IN FY 2022	
INFORMATION AND REFERRAL	**419**
REFERRED TO SCR HOTLINE	**85**
REQUEST FOR OIG INVESTIGATION	**219**
TOTAL CALLS	**723**

INVESTIGATIONS

This Annual Report covers the time period from July 1, 2021 to June 30, 2022 (FY 2022). The Investigations section is three parts. Part I includes summaries of full child death and serious injury investigations submitted to the Director of DCFS. 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 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

A 20-year-old mother placed her 2-month-old infant, her second child, to sleep in a baby swing. Approximately six hours later, she found the infant unresponsive and limp. The autopsy noted the infant had a .021 blood alcohol content, insect bites, dirty hands and feet, a blistering diaper rash, and general signs of neglect. The cause of death was ruled sudden unexplained infant death with unsafe sleep features. The manner was undetermined. A pediatric abuse/neglect specialist noted the infant had a petechial marking indicative of asphyxiation, and opined that all the circumstances of neglect, in addition to the unsafe sleep position, caused the death. The parents were indicated for death by neglect of the infant and cuts, bruises, welts, abrasions, and oral injuries to the sibling. The Department also indicated the parents for environmental neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect. Four months prior to the infant's death, the family's intact family services case had been closed.

INVESTIGATION

The Department first investigated the family the Child Abuse Hotline (the Hotline) received a report that the infant's then 16-year-old father lived with the then 19-year-old mother, who had given birth to her oldest child, the infant's sibling, the prior month. The mother and father confirmed their relationship to the child protection investigator, stating they had been dating for a year and had been living together for at least the last two months with the mother's grandmother. The Department indicated the mother for sexual penetration against the father, and the child protection investigator advised the couple they could not live together because of their ages.

While the first child protection investigation was pending, the Department initiated a second investigation after a nurse reported that a babysitter brought the then 1-month-old sibling to the hospital as he had difficulty breathing, and no one was able to reach the mother. The nurse stated the mother had previously brought the 1-month-old sibling to the hospital, and the sibling was diagnosed with croup, an infection of the upper airway that obstructs breathing and causes coughing. The parents were instructed not to smoke around the sibling, as that would exacerbate the condition, but the babysitter disclosed to the reporter that the home smelled of marijuana when she went to pick up the sibling.

The child protection investigator went to the hospital and hospital staff explained the sibling was discharged to the babysitter the night before with a prescription, but the babysitter brought the sibling back in the morning as the pharmacy would not fill the prescription without speaking to the mother. Hospital staff also reported that one month earlier, the sibling was diagnosed with failure to thrive. The mother told the child protection investigator that she fell asleep at a friend's home and her phone did not work. The babysitter confirmed that she initially brought the sibling to the hospital, where he was treated for croup and released with a prescription. The babysitter showed the child protection investigator the multiple text messages she sent to the mother and stated she also called the sibling's maternal great-grandmother, to no avail. The babysitter added that the mother had a history of substance use. The parents agreed to cooperate with intact family services and agreed the child protection investigator could place the sibling with relatives as part of a safety plan. The child protection investigator had the parents submit to a toxicology screening, and they tested positive for cannabis. The child protection investigator ended the safety plan after five weeks, as the mother reported scheduling appointments with WIC and the pediatrician. The Department closed the investigation and indicated the mother for medical neglect.

During the second child protection investigation, the child protection investigator referred the family to high-risk intact family services, and the case was assigned to a private agency. The child protection staff met with the intact worker and her supervisor to inform them of the sibling's diagnosis of failure to thrive and that he gained weight while residing with relatives during the safety plan. The child protection investigator also advised she spoke to a counselor who conducted a mental health and substance use disorder evaluation with the mother prior to the child protection investigations. The counselor reported the mother functioned at the cognitive age of a 12-year-old and did not understand the issues of having a sexual relationship with a minor or leaving the 1-month-old sibling with a friend. The child protection investigator informed the intact worker that the mother may need a psychological evaluation to determine her parenting capacity, as she lacked basic parenting skills. The intact worker documented the family needed parenting and infant care services, coordination of community-based services, and monitoring of the sibling's medical issues. The child protection investigator and intact worker went to the great grandmother's residence to visit the family, and upon arrival, they both noted the home strongly smelled of marijuana. The parents stated they smoked marijuana an hour prior to the visit, and the parents were informed that smoking marijuana was illegal since they were under 21. The worker referred the parents to substance use disorder services and mental health counseling with the goal of having them assessed for mental health, parenting capacity, and substance use. The intact worker made two additional weekly visits to the home and noted she observed the sibling and that the home did not smell of marijuana.

Less than a month after the intact family services case opened, the Hotline received an anonymous report that the parents were smoking marijuana while the then 4-month-old sibling was in the room. It was also reported that the parents placed the sibling in a bouncy seat, propped up a bottle, left him outside their bedroom while they slept. The reporter alleged the police were frequently called to the home for verbal altercations, but since the father was a minor, the police would send him to stay with his father for a few days. The reporter added the parents screamed at each other while the sibling was present, and it was believed the father was violent with the mother. A child protection investigator interviewed two maternal relatives, who reported they witnessed the unattended sibling crying in his bouncy seat. A relative added she saw the father beat the mother after the couple used drugs in the sibling's presence. The child protection investigator spoke to the parents, who admitted to daily marijuana use but did not believe smoking in the sibling's presence could harm him. The child protection investigator noted the sibling looked healthy and provided the parents with safe sleep education and appropriate bedding.

Throughout the third child protection investigation, the intact worker conducted visits with the family, and the parents reported participating in counseling sessions. The mental health provider told the worker the parents had not attended any sessions. The parents also failed to attend their first three toxicology screenings and then tested positive for cannabis in subsequent tests. Less than two weeks after the initiation of the child protection

investigation, the parents moved from the great grandmother's home into their own apartment. During this time, the intact worker documented consistently observing drug paraphernalia and marijuana in plain view, and at times, there was visible smoke in the air while the sibling was present. The intact worker discussed with the parents the hazards of smoking marijuana around the sibling, but the mother argued he was fine, and she had smoked marijuana throughout her pregnancy. Later in the intact family services case, the worker noted the father presented with cognitive delays. The father reported a history of serious mental health issues but did not take medication and self-medicated with marijuana, which he stated allowed him to control his emotions. The mother also told the intact worker she was previously diagnosed with anxiety and depression, and she also self-medicated with marijuana but denied using other drugs.

Less than a week before the third child protection investigation was closed, a relative told the intact worker that the mother slipped an unknown pill in the 5-month-old's formula to help with teething. The mother said it was a dissolvable teething pill, but she did not recall the medication's name and could not show the worker the pills. The worker spoke to the child protection investigator and supervisor about the unknown pill and the concerns regarding the continued exposure to secondhand marijuana smoke. After the discussion, the worker scheduled a toxicology screening with the sibling's doctor for his next wellness visit. The next day, the child protection investigator submitted a request to petition for protective custody to the assistant state's attorney (ASA), outlining the risks and parents' lack of cooperation with intact family services. The child protection investigator noted the ASA determined there was not enough information to take protective custody, but that the ASA would file a neglect petition for court intervention. Three days later, the child protection supervisor notified the intact worker and her supervisor of the investigation's closure and instructed them to call the Hotline if the sibling tested positive for drugs. The worker was also instructed to contact the police about the parents' underage marijuana use and the visible paraphernalia during visits. The worker told OIG investigators that she contacted the police, but the police did not consider the report serious because it only involved marijuana. The Department closed the child protection investigation and indicated the parents for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. The ASA had not filed a petition for court intervention by the time the child protection investigation closed.

The sibling's doctor made multiple attempts with the mother to schedule the next wellness visit, which took over a month to coordinate. The mother ultimately canceled the sibling's wellness visit and did not reschedule. The intact worker contacted the child protection investigator, reporting in the six weeks since the third investigation closed, the parents missed the sibling's wellness visit that included the toxicology screening, refused their own toxicology screenings, were not participating in services, and the mother was approximately two to three months pregnant and concealing her pregnancy. The worker stated she had not heard from the ASA regarding the petition, even though she had contacted him twice. The child protection investigator recommended the worker update the petition request to add these concerns and continue reaching out to the ASA. The child protection investigator also advised if the worker felt during a visit that the sibling was not safe, the worker should call the Hotline or police. Two weeks later, the mother took the then 7-month-old sibling to the wellness visit, but the medical staff told the worker that the mother became irate when it came time for the sibling's toxicology screening. The mother left before the test could be completed. The incident was reported to the Hotline but did not meet criteria to open an investigation. The parents became less cooperative with the worker. One month later, the intact worker staffed the case with her supervisor and administrator. The supervisor instructed the worker to follow up with the mother's doctor about her prenatal care and the ASA. The mother's doctor told the worker that she tested positive for marijuana and the doctor cautioned her about using marijuana while pregnant, advising it may cause growth restriction, which had been an issue with her first child, the sibling. The parents began to avoid the intact worker, so the worker conducted unannounced visits for the following month. The home did not smell of marijuana when the worker was able to see the family. Before speaking with the supervisor and administrator, the intact worker updated the request to petition for court intervention to include the worker's increasing concerns and the worker's attempts to contact the ASA on two occasions. The intact supervisor notified Department staff of the concerns regarding the family, which were

forwarded to the DCFS Supervisory Regional Counsel, who suggested the intact staff send a new request, along with the previous request, note that the child protection investigator spoke with the ASA, and include the updates since the last child protection investigation closed. The intact worker incorporated these recommendations and contacted the ASA three more times.

Seven months after the family's intact services case was opened, the case was closed unsuccessfully due to the parents' lack of compliance. Intact family services are voluntary unless there is a court order. The worker told OIG investigators that she still had concerns, but whenever she went to the home, the sibling appeared happy and healthy, and the parents followed safe sleep practices. In the five months after the Department closed the third child protection investigation, the worker documented seven attempts to contact the ASA, requesting to discuss the case and petition, but the ASA did not respond nor file the petition. The worker told OIG investigators that she also called the ASA's office, left messages, and went to the ASA's office at one point. OIG investigators interviewed the ASA, who reported little recollection of the case, except believing it did not rise to the level of filing a petition. The ASA did not recall the extent of the family's issues and could not explain why he never responded to the worker's multiple petitions and attempts to staff the case.

Three months after the intact family services case closed, the Department initiated a fourth child protection investigation when the mother gave birth to the infant, her second child; the infant tested positive for marijuana; and the mother admitted to using marijuana daily during her pregnancy. The next day, the child protection investigator spoke with the parents at their residence because the mother had signed herself out of the hospital against medical advice. The child protection investigator noted no concerns about the 14-month-old sibling and gave the parents a new pack-and-play. The child protection investigator also spoke with hospital staff, who stated they would discharge the infant later that day. Less than a week later, the Hotline received a report that the grandfather brought the infant to the hospital because the family's doctor said the infant had a high level of THC in her system and needed to be seen in the emergency department. The child protection investigator confirmed this with hospital staff, who stated the doctor requested the welfare check after the infant's tests stated she had a THC level greater than 500 ng/ml. The Mayo Clinic reports a THC level of 500 ng/ml or greater indicates chronic and recent marijuana use. The hospital staff noted the infant had no signs of cannabinoids intoxication and appeared well. The parents denied smoking marijuana in front of the children and declined intact family services. The child protection investigator spoke with the ASA, reporting three indicated child protection investigations in the last 15 months and explained the current concerns, but added she saw the children earlier that day, and the parents appeared to meet the minimal parenting standards. The ASA stated he would not file a petition because marijuana was legal. The Department closed the investigation and indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Four days later, it was reported to the Hotline that the mother missed three appointments for the infant's immunizations. The reporter added the grandmother disclosed that the parents smoked marijuana and cigarettes around the baby. The call was not taken for investigation. Less than two weeks later, the infant was pronounced deceased.

The intact worker consistently followed up with the ASA, detailing the risks to a young child and the parents' refusal to participate in services, but the ASA did not respond. The ASA's reasoning for not filing during the fourth child protection investigation was because marijuana was legal. This case highlights the importance of ensuring that court personnel understand and recognize the risk presented to children when parents fail to cooperate with services, including unaddressed mental health issues, developmental delays, and continued substance use. The intact staff sought help from the Department, but DCFS Office of Legal Services staff directed the intact worker back to the state's attorney and did not provide direct assistance.

RECOMMENDATIONS

1. This report should be shared with DCFS Office of Legal Services.

The Department agrees. The report was shared with DCFS Office of Legal Services.

2. The OIG reiterates its recommendation from prior report, 2018 IG 1487: DCFS Office of Legal Services should meet with their local State's Attorneys at least annually to discuss the use of protective orders in cases that do not rise to urgent and immediate necessity.

The Department agrees. In December 2021, the Deputy General Counsel, in conjunction with staff from the Administrative Office of Illinois Courts (AOIC), presented a training to judges and other court stakeholders on the use of protective orders. In addition, DCFS attorneys throughout the state meet regularly with State's Attorney's to discuss various issues including the use of protective orders.

3. The OIG reiterates its recommendation from a prior report, 2018 IG 1487: 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 agrees. The DCFS Office of Legal Services has collaborated with the Division of Child Protection (DCP) to develop guidance for child protection investigators who encounter barriers with local State's Attorneys when seeking court involvement.

4. This report should be shared with the involved county's State's Attorney's Office.

The OIG has shared the report.

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

The OIG has shared the report.

6. This report should be shared with the Division of Clinical Practice Behavioral Health/Substance Use group. The group should develop guidelines around assessment of marijuana use and its impact on parenting.

The Department agrees. The report has been shared and will be utilized in the development of guidelines around this issue.

DEATH AND SERIOUS INJURY INVESTIGATION 2

DEATH A child born with fatal congenital conditions died a day after birth. The autopsy determined the cause of death as cardiovascular collapse skeletal dysplasia, and the manner of death as natural. The Department did not investigate the newborn's death for abuse or neglect. There were two unfounded child protection investigations in the year prior to the newborn's death involving the newborn's mother and siblings.

INVESTIGATION Nine months prior to the newborn's death, the mother was involved in two unfounded child protection investigations. The Department first investigated the mother after the Hotline received a report that the mother physically abused the newborn's then 12-year-old half-sibling. The 12-year-old's father reported the abuse to the police. The father explained he lived out of state and the mother had guardianship of the 12-year-old, but the sibling had lived with fictive kin for most of her life and would only occasionally stay with her mother. The fictive kin reported to the police that the mother was no longer allowing the 12-year-old to stay with the fictive kin and that the sibling sent text messages stating the mother punched her and hit her with a belt. The father and fictive kin urged the police to take protective

custody, but the officer stated they could only intervene if they observed the child with serious injuries, which no one had yet observed.

A child protection investigator went to the home and met with the 12-year-old, who was watching her 9-year-old and 7-year-old half-siblings while her mother was out. The child protection investigator spoke briefly to the children at the front door, and the 12-year-old stated she felt unsafe in her mother's home, and she wanted to leave because her mother hit and spanked her. The child protection investigator noted the 12-year-old had a red mark on the side of her leg and on her arm but described them as small and faint. The two other children reported they felt safe in the home. The 9-year-old stated he was spanked or had his electronics taken away as punishment, and the child protection investigator noted no injuries were observed on the child. The mother returned home, told the children to go inside, slammed the door, and refused to speak with the child protection investigator. Law enforcement arrived at the home to assist the child protection investigator. The mother reluctantly spoke to the child protection investigator and reported she occasionally spanked her children to discipline them. She denied she punched the 12-year-old but admitted she spanked her with a belt. The mother refused to allow the child protection investigator or law enforcement to come into the home but permitted the child protection investigator to observe the 7-year-old, who had no visible injuries. Two weeks later, the mother was unfounded for substantial risk of physical injury/environment injurious to health and welfare. The child protection staff noted the discipline did not rise to the level of abuse, and the allegations were the result of the parents' custody dispute. The child protection investigator told the father the Department could not intervene in custody issues but offered to provide him information on how to file a petition to the court for custody of the child.

Less than three weeks later, another report was made to the Hotline alleging the mother physically abused the 12-year-old while the child had a friend over. It was reported the friend left soon after the mother began hitting the child and then the police were called. A child protection investigator contacted the friend's mother, who stated her child was panic-stricken and asked her to pick her up from the 12-year-old's home. The friend told the child protection investigator she was at the home when the mother slapped the 12-year-old and then took her to another room, but the friend could hear her scream. The child protection investigator contacted the police, and they reported they conducted a wellness check but did not observe any bruising and did not have any concerns. The child protection investigator went to the home, but the mother confronted him and was verbally aggressive. The 12-year-old came to the front door, and when the mother was distracted by calling her attorney, the child protection investigator asked the 12-year-old if she felt safe in the home, and the child whispered she did not feel safe. After speaking to the attorney, the mother allowed the child to step out onto the sidewalk to speak with the child protection investigator, but the mother interfered and recorded the interview. The child protection investigator noted the child appeared very uncomfortable responding to the questions while the mother was listening and frequently interrupted. The child protection investigator asked the child again if she felt safe, but this time the child stated she felt safe in the home. The child protection investigator told OIG investigators that the child did not appear to be afraid or under duress when she changed her answer, which was why she was not taken into protective custody. The child protection investigator also observed no bruising on the child. The mother did not allow the child protection investigator to interview the siblings or observe the inside of the home.

The child protection investigator attempted another visit, but the mother stated the child protection investigator had to contact her attorney, who was also not cooperative. The child protection supervisor instructed the child protection investigator to send the attorney a subpoena and visitation order through certified mail. After several phone calls to the attorney, the attorney eventually arranged for the child protection investigator to observe the children but prohibited the children from being interviewed. The child protection investigator observed the two younger siblings outside the home, as the mother denied access to the residence, and noted the children appeared healthy, clean, and without visible injuries. The child protection investigator did not observe the 12-year-old and did not arrange to see her. The second child protection investigation was closed less than a month after the

allegations were reported, and the Department unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare.

Although the mother's attorney impeded the investigation, the child protection staff involved in the second investigation did not request assistance from the DCFS Office of Legal Services to pursue a court order to interview the children or assist with communicating with the mother's attorney. DCFS procedures allow for child protection investigators to consult DCFS Office of Legal Services to pursue a court order if the adult caregiver prohibits the child protection investigator from observing or speaking with the children.

RECOMMENDATIONS

1. This report should be shared with the child protection investigator and supervisor involved in the second investigation for training purposes.

The Department agrees. The report will be shared with the involved child protection investigator and supervisor.

2. DCFS Office of Legal Services shall issue a written communication to child protection staff outlining the appropriate use of Regional Counsel as an available resource when parents and/or their attorneys are uncooperative.

The Department agrees. The Division of Child Protection and Office of Legal Services developed guidance for the field related to this issue. The guidance has been shared with Regional and Area Administrators.

3. This report should be shared with the Simulation Labs to create a training scenario addressing uncooperative parents and/or legal counsel during a child protection investigation.

The Department agrees. The current simulation scenarios involve interactions with uncooperative parents. The Department will highlight in Foundations Training and regional legal in-service trainings the need for child protection staff to consult with DCFS Regional Counsel when child protection staff encounter an uncooperative parent and/or uncooperative private legal counsel.

DEATH AND SERIOUS INJURY INVESTIGATION 3

DEATH

A 1-year-old was attacked by the family dog after she reached for the dog's food bowl. Family members pried the dog off the child and called 911. Emergency services transported the child to the hospital, where she was pronounced deceased. At the time of the incident, the child and 6-year-old maternal half-sibling lived with the maternal grandmother. The Department initiated a safety plan to place the maternal half-sibling with his paternal grandmother and subsequently indicated the maternal grandmother for death by neglect. There were three indicated child protection investigations within the year prior to the child's death involving the child's mother, maternal grandmother, and siblings.

INVESTIGATION

The maternal grandmother had extensive history with the Department, which included 29 child protection investigations, a failed intact family services case resulting in a placement case, and four Hotline calls not taken for investigation. The placement case began in 2008 and closed in 2012, after the court returned guardianship of the four children to the grandmother. Two years later, in 2014, the child's maternal half-sibling was born to the grandmother's teen daughter. That year, the Department indicated the maternal grandmother for substantial risk to three of her children and the maternal half-sibling due to domestic violence between the grandmother and her then-paramour. In 2015, the Department investigated and unfounded the grandmother for an investigation involving the maternal half-sibling and the

child's mother. In 2016, the Department investigated the grandmother three times; two were unfounded and one investigation was indicated for cuts, bruises, welts, abrasions, and oral injuries to the grandmother's then 13-year-old son. Later in 2016, the grandmother obtained private guardianship of the then 2-year-old maternal sibling. The following year, the Department unfounded the grandmother for inadequate supervision of the maternal sibling.

In 2018, the Department initiated an investigation after the then 4-year-old maternal sibling disclosed that his mother had hit him with a belt. Medical staff observed a bruise on the maternal sibling but did not know when the injury occurred. A child protection investigator interviewed the sibling, who stated he lived with his mother and maternal grandmother, and he hurt himself when he fell from his bike. The Department unfounded the mother and maternal grandmother and assessed that the family did not need services.

Two years later, in 2020, the Department initiated an investigation after the mother and the child, then a newborn, tested positive for cocaine. The mother reported she used cocaine a week prior to the birth and had not received prenatal care. The child protection investigator met with the mother and maternal grandmother at the hospital, and the mother stated she wanted to attend inpatient substance use disorder treatment and planned to give the grandmother guardianship of the child. The child protection investigator advised if the mother gave guardianship to the grandmother, the mother would be ineligible for intact services; however, if the mother maintained guardianship, the mother could participate in services while the grandmother cared for the then newborn child. The mother agreed to not be alone with the child or remove the child from the grandmother's home, but the child protection investigator did not implement a safety plan. The mother agreed that if she did not complete treatment, she would give the grandmother guardianship. Less than two weeks later, the grandmother requested guardianship paperwork from the child protection investigator because the mother had not entered treatment, due to the pandemic, and had left the home.

Before closing the investigation, the child protection investigator received police records involving the family, which included a warrant executed at the maternal grandmother's previous residence a month before the child's birth. The child protection supervisor approved the child protection investigator's assessment that the child was safe with the grandmother and to allow her to seek guardianship of the child. The supervisor told OIG investigators that he was familiar with the family's history but explained the maternal grandmother was last indicated in 2016 for cuts, bruises, welts, abrasions, and oral injuries to her then 13-year-old son. The Department indicated the mother for substance misuse by neglect and closed the investigation. In her OIG interview, the child protection investigator stated she did not offer intact family services because the grandmother did not require services. Months later, the maternal grandmother filed a petition to obtain guardianship but failed to appear at the court date. The grandmother also failed to appear at the second hearing, and never acquired legal guardianship of the child prior to the child's death.

Approximately six months later, it was reported to the Hotline that the then 6-year-old maternal half-sibling was brought to the emergency department by his father because he had an abrasion, and the side of his face was swollen. The 6-year-old disclosed that his 15-year-old maternal uncle had kicked him in the face the prior evening. A child protection investigator met with the sibling and his father that day. The father explained he was in prison when the maternal grandmother obtained guardianship of the sibling four years earlier, but the sibling had been staying with his father during the week and would spend the weekends with the maternal grandmother. The father reported he observed the injury when the sibling returned from his visit with the grandmother. The sibling stated the maternal uncle tripped him and kicked him in the face, and the grandmother was at the home when it happened. The child protection investigator observed the injuries, and the sibling reported the grandmother instructed the sibling to say he hit his face on the furniture. The sibling also stated the grandmother, mother, and uncle would spank him with their hand, but the sibling denied being fearful of anyone in the home. The child protection investigator also obtained police reports that included two separate incidents within the prior six months, in which it was reported bullets struck the maternal grandmother's home. No one in the residence was reportedly injured. There was also a report that police responded to the residence

due to a physical fight between the grandmother and an adult relative, which occurred a month prior to the call to the Hotline for the sibling's facial injuries. The child protection investigator met with the grandmother, the 15-year-old uncle, and the child, who was then 9 months old. The 15-year-old reported the maternal sibling would not get off his lap, so the uncle pushed him off and the sibling hit his face on a chair. The uncle stated he did not intend to hurt the sibling and acknowledged he responded poorly. The grandmother confirmed the uncle's statement and added she applied an ice pack to the sibling's face and gave him Tylenol. The grandmother stated they behaved like siblings rather than nephew and uncle but denied prior incidents between the two. The grandmother also told the child protection investigator that she had guardianship of the then 9-month-old child and had not seen the mother. The Department closed the investigation and indicated the 15-year-old uncle. The supervisor told OIG investigators that the child protection investigator offered services to the grandmother, but she refused.

While the investigation involving the sibling and the uncle was pending, the Department initiated another investigation after police were called to the 6-year-old's father's residence for a verbal dispute between the father and his paramour. The father reported that he and his paramour fought after an incident between the 6-year-old and the paramour's 10-year-old child. Following an investigation, the Department indicated the 6-year-old's father for inadequate supervision.

Child protection staff allowed the maternal grandmother to seek guardianship of the child after she was born substance-exposed, but the staff did not initiate intact family services nor Extended Family Support Program (EFSP) services to help the family or mitigate the risk factors. The overall goal of EFSP is to stabilize children living with a relative caregiver, which is primarily done by helping the caregiver obtain guardianship in probate court and provide other services to enable the relative to care for and meet the children's immediate and long-term needs. However, in this case, the maternal grandmother was left with a temporary guardianship paper and no assistance nor services. Approximately eight months later, the Department became involved with the family again after initiating an investigation into the maternal sibling's facial injuries and learned that the maternal grandmother had still not obtained full guardianship of the 1-year-old child.

RECOMMENDATIONS

1. This report will be used by OIG in Error Reduction training on decision-making practices in child protection.

The report has been shared with OIG training staff for inclusion in Error Reduction Training.

2. This report should be shared with the Regional Administrator of this jurisdiction. The RA should work with the OIG ERT team in facilitating a discussion about this case with child protection staff in this region.

The Department agrees. The report has been shared with the Regional Administrator.

3. This report should be shared for training purposes with the child protection investigators and supervisors involved in the investigations involving the child's birth and the maternal sibling's facial injuries.

The Department agrees. The report was shared with the involved staff for training purposes.

4. The Department should create policy for when and how to use temporary guardianship during a pending child protection investigation.

The Department agrees. The Department will issue communication to the field on the appropriate use of temporary guardianship. In addition, child protection staff will receive training on appropriate use of temporary guardianship.

5. When temporary guardianship is utilized during a pending child protection investigation in lieu of protective custody, the Department must offer a minimum of Extended Family Support Program Services.

The Department agrees. The Department will issue a reminder to child protection staff.

DEATH AND SERIOUS INJURY INVESTIGATION 4

DEATH

A 2-month-old was brought to the emergency department with a head injury and bruising to his face. The mother brought the infant to the hospital after returning home from work and finding the infant lethargic and unable to eat. The infant had been in the care of his father while the mother was at work, and the father reported the 1-year-old sibling had hit the infant in the face with a toy. A CT scan showed trauma to the brain, a contusion to the scalp, and bleeding on the brain in four separate areas. Physicians believed the trauma was non-accidental abuse based on the severity of the injuries. The infant was listed in critical condition and died six days later. Following the death, the 1-year-old sibling and 7-year-old half-sibling came into the care of the Department. The Department indicated the mother and father for the infant's death and for substantial risk of physical injury/environment injurious to health and welfare. The father was also indicated for head injuries and was subsequently arrested and charged with murder. In the year prior to the infant's death, there was one unfounded child protection investigation involving the family.

INVESTIGATION

Ten months before the infant's death, it was reported to the Hotline that the father was sexually abusing the then 6-year-old half-sibling. The reporter stated they did not know if the mother was aware of this as she misused pills. The Department unfounded the mother and father after the half-sibling participated in a forensic interview and stated no one had sexually abused him. The mother also denied the drug use allegations, advising she was a few weeks pregnant. During the child protection investigation, the child protection investigator learned that less than two years prior, there had been a domestic incident between the mother and father, but the father had participated in domestic violence classes, and the mother stated there had not been another incident. The child protection investigator discussed intact family services with the mother, who agreed to cooperate with the services. However, an intact case was not opened, and the child protection investigator noted in the State Automated Child Welfare Information System (SACWIS) the request to open an intact family services case was denied and included an email from an intact administrator. The child protection staff believed the case had been deemed ineligible for intact services. The child protection investigator provided the mother with information about specific resources in her community, and the mother agreed to schedule appointments.

This child protection investigation occurred during a shortage of intact workers and resources coinciding with the COVID-19 pandemic. The child protection staff that oversaw this investigation told OIG investigators they observed an increase in the denial of intact family services requests during this period, especially with unfounded investigations, but that the situation has improved, and more intact family services resources have become available.

An intact administrator told OIG investigators that she did not deny the request for intact services for this family. The administrator stated she often had to request additional information from the child protection staff to approve the intact family services requests, which she did for this case, but did not receive the requested information from the child protection staff. As part of the information request, the intact administrator asked about the family's service needs that could not be met in the community. The child protection investigator stated she discussed the information request with her supervisor but stated as she had no additional information to send, they decided to refer the family to community resources, believing this was their only option at that

time. The child protection investigator told OIG investigators that she would have preferred for the family to receive intact services, but the community providers in that area were known to be very helpful.

RECOMMENDATIONS

1. This report should be shared with the child protection investigator, supervisor, and area administrator for training purposes.

The Department agrees. The report has been shared for training purposes with the involved staff.

2. The Department should amend the CFS 2040 referral form to reflect notification to the referring person of whether the case has been accepted, denied, or if more information is needed to make a determination and that mechanism should be built into the Comprehensive Child Welfare Information System (CCWIS).

The Department agrees. The recommendation has been incorporated in revisions to CFS-2040. The revisions will be posted for Proposed Policy Review by the Office of Child and Family Policy.

DEATH AND SERIOUS INJURY INVESTIGATION 5

DEATH

A 6-month-old infant was found unconscious and not breathing by his 22-year-old mother. The mother reported she was unable to call 911 for over an hour because her cell phone battery was dead. When first responders arrived, the infant's body was in rigor mortis with no obvious signs of trauma or injury. The Department implemented a safety plan for the infant's three surviving siblings to stay with relatives. According to the autopsy report, the cause and manner of death were ruled undetermined and the Department unfounded the parents for death by neglect. Prior to the infant's death, the family was investigated three times by the Department for allegations of abuse or neglect. The most recent child protection investigation was initiated seven months prior to the infant's death and unfounded two months prior to the death.

INVESTIGATION

The family first came to the attention of the Department in 2018, prior to the deceased infant's birth, when the Hotline received a call alleging that the parents had physical altercations in front of their then 2-year-old and 1-year-old children and that the father hits the children. The next day, the child protection investigator documented she made a good faith attempt to see the children. The following week there was another report to the Hotline with similar allegations. Four months after the initial Hotline call, the children were still not seen, and a different child protection investigator was assigned to the investigation. The new child protection investigator called the reporter and learned the then 20-year-old mother and children had moved out of state. The child protection investigator spoke with the mother, who confirmed moving out of state, and then had local law enforcement conduct a welfare check. Police confirmed the children were safe. Less than three weeks after the investigation was reassigned, the Department indicated the father for substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect and closed the child protection investigation.

Approximately nine months later, an anonymous caller reported to the Hotline that there was significant mold in the home where the mother and her then three children were living with a maternal aunt. The aunt informed the child protection investigator that the mother and children did not live with her, and it took almost two months for the child protection investigator to locate the mother. Once the family was located, the child protection investigator observed the then 3-year-old, 2-year-old, and 8-month-old siblings to be safe, and the Department unfounded the mother for environmental neglect that same day.

Less than six months later, the Department investigated the family a third time, after receiving an anonymous report that the mother and maternal aunt used substances and were not properly caring for the children. The child protection investigator attempted to see the family on the same day the Hotline report was received, and the following week, to no avail. Two months after initiating the investigation, and after three additional attempts, the child protection investigator located the family. During the in-person visit, the child protection investigator learned the mother had given birth to the infant days after the investigation was initiated. The child protection investigator noted the infant and his three siblings had no marks or bruises. The mother denied the allegations and admitted to occasional alcohol and marijuana use.

During the third child protection investigation, the family's primary doctor informed the child protection investigator that the 4-year-old and 3-year-old siblings had not had medical appointments over two years and needed updated immunizations, and the 1-year-old sibling and infant had never been seen at their facility, but the infant had an upcoming appointment. The mother stated she scheduled appointments for her children, but the following week, she notified the child protection investigator that the appointments were canceled by the clinic. The child protection investigator instructed the mother to reschedule the appointments but did not follow up to ensure the mother took the children to the doctor prior to closing the investigation. According to medical records, the mother failed to bring the infant to a rescheduled appointment or any well-child exams prior to his death, and the three surviving siblings were not seen by a doctor until after the infant's death. The child protection investigator told OIG investigators she did not know how often a healthy baby should be seen by a doctor. The American Academy of Pediatrics (AAP) emphasizes the importance of regular medical visits throughout a child's life and developed the periodicity schedule for children, which is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. The AAP stresses the critical importance of infants being examined by a doctor at the ages of 3-5 days old, 1 month, 2 months, 4 months, 6 months, and 9 months to ensure the child is not experiencing any developmental, psychosocial, or chronic disease issues that may require further intervention or follow-up.

Additionally, during the third child protection investigation, the child protection investigator discussed intact family services with the mother, who agreed to participate, and the child protection investigator emailed a referral for intact services to her supervisor. The Department indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to all four of her children. Two months prior to the infant's death, the investigation was closed without the child protection staff ensuring the family was connected to intact family services.

Nine days before the third investigation closed, the supervisor documented in SACWIS that the family would be referred for intact family services for parenting services, individual counseling, and domestic violence services. On the day the investigation closed, the area administrator noted in SACWIS that the family was referred for intact services. However, OIG investigators found no evidence that the supervisor sent the intact request to the area administrator for approval, and intact staff reported that no referral was submitted during the child protection investigation. The supervisor could not recall how the referral was submitted. Department Procedures 302.388(c)(2), *Supervisor Approval or Disapproval*, requires child protection supervisors to submit the form for intact services to their area administrator "via Department email." Additionally, Department Procedures 302.388(e), *Case Creation, Opening, Assignment and Transfer*, dictates that the child protection supervisor is responsible for creating the family case in SACWIS, and the intact family case must be created before the investigation is completed and closed in SACWIS.

RECOMMENDATIONS

1. This report should be shared with the child protection investigator from the third investigation for training purposes.

The Department agrees. The report will be shared with the involved child protection investigator for training purposes.

2. The child protection supervisor from the third investigation should be counseled for her failure to ensure the family was referred for Intact Family Services in the third investigation as outlined by procedures 302.388.

The Department agrees. The child protection supervisor will be counseled.

3. This report should be shared with the regional administrator.

The Department agrees. The report has been shared with the regional administrator for training purposes.

4. Child protection specialists and child welfare services staff should be trained on the recommended periodicity schedule for children.

The Department agrees. The medical periodicity schedule for children was reviewed with DCFS and private agency intact family services staff at a statewide training meeting. All permanency staff have received a copy of the medical periodicity schedule for children. DCFS and private agency permanency staff also received training on this topic. Child Protection Administrators are collaborating with the DCFS medical director to develop a laminated timeline to provide to child protection staff with the recommended periodicity schedule for children. In addition, the involved agency conducted a Medical Timeline training and training on 0-3 Developmental Screenings for their staff.

5. Procedures should require that when a child protection investigator learns that a child 1 month old to 12 months old has never been seen by a doctor, the child protection investigator should ensure the child is seen.

The Department agrees. The recommendation will be incorporated in revisions to Procedures 300, *Reports of Child Abuse and Neglect*.

DEATH AND SERIOUS INJURY INVESTIGATION 6

DEATH

A 5-month-old infant was found unresponsive after co-sleeping in a bed with his 26-year-old mother. The infant was lying on his side and facing the wall with a pillow between him and the wall, and his mother laid behind him. The mother awoke to find the infant was not breathing and called 911. The 5-month-old had been recently discharged from the hospital after being diagnosed with respiratory syncytial virus. The autopsy concluded the infant's death was accidental, caused by asphyxia, due to the infant sleeping in soft bedding and co-sleeping in a bed with an adult. The Department unfounded the mother for death by neglect, citing no evidence of blatant disregard for the deceased infant. The infant's mother had one prior unfounded child protection investigation in the year prior to the infant's death.

INVESTIGATION

In 2014, the family first came to the attention of the Department, after the Hotline received a report of substance use and domestic violence between the mother and the father of the oldest maternal half-sibling. The Department unfounded the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect to the oldest maternal half-sibling.

Approximately one year prior to the infant's death, it was reported to the Hotline that the then 6-year-old maternal half-sibling disclosed to her maternal great grandmother that she was inappropriately touched by the infant's father while the mother was at work. After the mother was informed of the allegations, the mother

spoke with law enforcement, filed for an emergency order of protection, and moved her three children out of the father's home to stay with the great grandmother. The day after the Hotline report, a child protection investigator went to the great grandmother's residence and interviewed the great grandmother, as the mother and children were not home. On that same day, the child protection investigator also contacted the county's Children's Advocacy Center (CAC) to complete an intake form and stated she would contact the CAC "if and when a CAC is needed." Three days later, the mother called to inquire when the CAC interview would be scheduled, and the child protection supervisor instructed the child protection investigator to follow up with the mother.

Almost two months after the Hotline call, the child protection investigator met with the mother and children for the first time. The child protection investigator asked the 6-year-old about the allegations while the mother was present, and the child stated she had trouble remembering and then denied the allegations. The child protection investigator did not notify law enforcement nor CAC staff prior to interviewing the child. The child protection investigator told OIG investigators that the standard practice was to speak to the child in a limited fashion prior to seeking a CAC interview, and if the child did not disclose the sexual abuse to the child protection investigator, then no CAC interview would be scheduled. The child protection investigator also spoke to the mother that day, and the mother stated she wanted to support her daughter, but she no longer believed the allegations were true. The mother added she thought the child might have made up the allegations after the child got into trouble for saying she wanted to live with the great-grandmother. The child protection investigator reported in the OIG interview that she did not recall if the mother said she no longer wanted a CAC interview during that visit, but stated the mother later told the police that she did not want a CAC interview. After the meeting with the mother and the children, the child protection investigator informed her supervisor, CAC staff, and law enforcement that the child recanted her statement about the sexual abuse.

Two months after the child protection investigator interviewed the mother and child, the area administrator approved an extension request because the father still needed to be interviewed. The area administrator told OIG investigators that when she granted the extension, she did not know that the child protection investigator interviewed the child with her mother present and without a CAC interview. Two weeks after the extension was granted, the child protection supervisor told the child protection investigator since the child recanted her statement, the CAC interview was not needed. Almost five months after the Hotline report, the Department unfounded the father for sexual abuse.

According to DCFS Procedures 300, in allegations of sexual abuse, the child protection staff should work with their local CAC to schedule a forensic interview with the alleged child victim. The purpose of a CAC interview is to minimize the number of times the child recounts the events and reduce the re-traumatization. CACs employ forensic interviewers, who are specifically trained to conduct sensitive interviews to elicit the most truthful information from an alleged child victim. Further, all interviews, including forensic interviews, are most effective when conducted in a timely manner. Because a child's recollection deteriorates over time, an impartial forensic interview should be conducted as soon as possible.

RECOMMENDATIONS

1. This report should be shared with the child protection supervisor for training purposes.

The Department agrees. The report has been shared with the child protection supervisor for training purposes.

2. This report should be shared with the area administrator for training purposes.

The Department agrees. The report has been shared with the area administrator for training purposes.

3. This report should be shared with the local Regional Counsel.

The Department agrees. The report has been shared with the local Regional Counsel.

4. A communication clarifying the protocol for coordinating with the Children's Advocacy Center should be issued to child protection staff in this region.

The Department agrees. The protocol was shared with child protection staff in the involved region at an all-staff meeting.

5. This report should be shared with the child protection investigator's current employer for supervision purposes, since this individual is currently employed at a private agency that is under contract with DCFS.

The Department agrees. The report was shared with the current employer for supervision purposes.

DEATH AND SERIOUS INJURY INVESTIGATION 7

DEATH

A 19-year-old mother awoke to find her 10-month-old infant unresponsive next to her in bed. The mother admitted that in attempting to get the infant to sleep, she held the infant against her until the infant stopped moving. The mother reported she then fell asleep and awoke to find the infant not breathing. The mother pleaded guilty to involuntary manslaughter and was sentenced to nine years in prison. The Department indicated the mother for death and substantial risk of physical injury/ environment injurious to health and welfare by neglect and for tying/close confinement to her 2-year-child. The father was indicated for tying/close confinement and substantial risk of physical injury/environment injurious to health and welfare by neglect to his 2-year-old stepchild. There were two prior unfounded child protection investigations involving this family within a year of the infant's death.

INVESTIGATION

The mother was involved in six child protection investigations as a minor, two of which were indicated. At the age of 16, the mother had her first child, and eight months later, the Department investigated her for inadequate supervision of that child. The individual who reported the allegation to the Hotline later retracted her statement, and the report against the mother was unfounded.

A year and half later, the Department initiated an investigation when the Hotline received a report that the 20-year-old father of the then 4-month-old infant, the deceased, left bruises on the 2-year-old half-sibling, and the 18-year-old mother did not intervene. The reporter also alleged the mother and maternal grandfather would blow marijuana smoke in the 2-year-old's face, and the family would neglect the 2-year-old leaving him unattended in his playpen all day. The child protection investigator observed no marks or bruises on either child. The family lived with multiple people; the mother, who was pregnant with her third child, explained they were staying with relatives while they were on the public housing waitlist. The child protection investigator noted there was no odor of drugs in the home, and the adults' toxicology screenings were negative. The child protection investigator interviewed the six adults in the home, who all stated they did not witness anyone smoke marijuana around the children, nor physically harm them.

The child protection investigator spoke to the mother's 13-year-old sister, the deceased's aunt, at school, who stated the mother and grandfather did smoke marijuana around both children. The sister also shared that she had no concerns about the stepfather hurting the 2-year-old but indicated the mother would spank and be rough with the 2-year-old, though she had not seen any bruises on the child. The teen added that the mother had previously broken the grandfather's wrist during an argument. The 13-year-old aunt reported she felt safe in the home. The child protection investigator did not follow-up on the discrepancies reported by the aunt. By the

end of the investigation, citing insufficient evidence, the Department unfounded the stepfather for substantial risk of physical injury/environment injurious to health and welfare, the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect, and the mother and grandfather for substance misuse.

Three months after the second investigation closed, the mother brought the 2-year-old to the hospital after the sibling appeared to have a seizure after the mother spanked him. The Department was notified that the mother, who was approximately eight months pregnant, became extremely upset when medical staff began to examine the sibling's back. She started to explain the sibling had bruises from falling earlier, but medical staff did not see any bruising on the back. At the hospital, the child protection investigator photographed a red mark on the sibling's thigh and noted no other bruises. There were also no bruises on the then 9-month-old infant. The hospital staff voiced no concerns as medical scans showed no evidence of abuse, and a nurse stated she could not believe how patient the mother was with the 2-year-old, who appeared to have behavioral issues.

Three days later, the child protection investigator visited the family, who was no longer living with relatives and moved into their own home. The mark on the child was gone and there was no bruising on either child. The child protection investigator spoke with the mother about appropriate discipline, and she stated she typically used time outs but admitted she occasionally swatted the 2-year-old over the pants with her hand. The mother had also reached out to a community organization to receive assistance with the child's behavioral issues. The child protection investigator contacted the organization, and they confirmed they conducted a virtual assessment and would be working with the family. The Department unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries; and cited the spanking, while not appropriate, did not rise to the level of abuse.

The 10-month-old infant died approximately one month after the third investigation closed. The child protection investigator from the third investigation told OIG investigators that in addition to seeing the children at the hospital, he made two separate unannounced visits to the home and never observed anything concerning. The child protection investigator stated he made more than the required number of contacts with the family because the investigation involved two very young children, and the child protection investigator wanted to ensure they were safe.

Throughout the investigation into the child's death, paternal family members told the child protection investigator they were concerned by the mother's violent behavior with the 2-year-old, as she would spank or shove the child. Multiple family members also stated the 2-year-old was left unsupervised and confined in a playpen, highchair, or room for most of the day. When questioned, the father confirmed the allegations were true, stating the mother told him it was the best method to handle a child with behavioral issues.

These child protection investigations were conducted in an area that conducts a high volume of child protection investigations. Department records indicate the field office had enough child protection investigators to comply with the caseload requirements in the B.H. Consent Decree, however, parallel investigations are not counted in caseload totals. During interviews with OIG investigators, the child protection investigators and supervisors stated their office has conducted several parallel investigations due to the number of medical facilities in the area. The Department did not consider parallel assignments, or the time spent by child protection investigators on completing needed tasks, in determining investigative workload. Additionally, child protection investigators informed the OIG about difficulties in obtaining critical medical records and information from doctors in a timely manner, which has hindered their investigations.

RECOMMENDATIONS

1. A copy of this report should be shared for training purposes with the child protection investigator and supervisor from the second child protection investigation and the child protection investigator from the third child protection investigation.

The Department agrees. The report was shared with the involved staff for training purposes.

2. The Department should develop a system to track parallel assignments to better account for the full workload of child protection investigators. These results should be shared with area administrators.

The Department agrees. Parallel assignments are tracked at the site level and this data is shared between child protection supervisors and area administrators.

3. The Department should collaborate with hospitals/medical systems for which obtaining records and/or information has been identified as problematic, to allow for a more efficient and timely exchange of information.

The Department agrees. The Office of Legal Services conducted training on the use of administrative subpoenas when a hospital, medical provider or community partner denies a request for records. In addition, the Office of Legal Services will continue to explore collaboration with hospitals and medical systems to ensure a timely sharing of information.

4. The child protection investigator should be acknowledged for her thorough and persistent work in the investigation into the child's death.

The Department agrees. The child protection investigator was commended for her work on the involved child protection investigation.

DEATH AND SERIOUS INJURY INVESTIGATION 8

DEATH

A mother reported she checked on her 7-year-old child in the middle of the night and found him not breathing. The child's autopsy revealed the cause of death to be suffocation and the manner of death was homicide. The mother was charged with first degree murder and aggravated battery to a child. The Department unfounded the mother and father for death by abuse and indicated both parents for death by neglect, citing that the mother denied she caused the child's death. The father was also indicated for substantial risk of physical injury/environment injurious to the child. The family had an extensive history with the Department including an unfounded child protection investigation within a year of the child's death.

INVESTIGATION

Since 2013, the mother had been involved in 15 child protection investigations, 13 of which were unfounded, largely stemming from the mother's mental health and substance use issues. In March 2014, an intact family services case was opened following a Hotline report that the then 5-month-old child had scratches over his face and head, and the then 4-year-old maternal half-sibling was in the car when the mother drove to a counseling appointment while she was overmedicated and intoxicated. The mother was subsequently admitted to the hospital. While the mother was hospitalized, the two maternal half-siblings stayed with their father, and the child resided with fictive kin as part of a safety plan. The child returned to his parents in July 2014. Four months later, the intact case closed. In 2015, the mother was involved in three child protection investigations, and the Department indicated the mother in one of those investigations for cuts, bruises, welts, abrasions, and oral injuries to the then 6-year-old maternal half-sibling. Additionally, between 2018 and 2020, there were five child protection investigations involving the family, all of which were unfounded.

In April 2019, the Department initiated a child protection investigation after the father brought the mother to the hospital due to an overdose, and the mother disclosed she took the pills while she was alone with her

children. The mother added she knew the father would be home soon and felt they all would be better off without her. The mother was admitted to the hospital. The mother signed a consent for release of information that allowed the Department to have access to her medical and mental health information. The child protection investigator saw the children that day, and the children reported feeling safe in their home. Almost a month later, the child protection investigator contacted the mother, who stated she was doing better since she was discharged and was attending counseling twice a month. The child protection investigator scheduled a visit with the mother, but two weeks later, the father called to reschedule the visit for that day because the mother was back in the hospital. The child protection investigator requested, received, and reviewed the mother's hospital records. The child protection investigator also requested records from mother's mental health provider, but OIG investigators found no evidence that these records were obtained nor was there any documentation that anyone spoke with mental health treatment providers. Five days after requesting the mental health provider's records, the Department unfounded the mother due to insufficient evidence. The child protection supervisor agreed with the recommended unfounded finding noting that the mother took the pills knowing the father would be home soon, and that the children were unaware of the overdose.

Less than two months later, the Department initiated an investigation after the mother was again hospitalized for suicidal ideation and an overdose. It was reported to the Hotline that the mother's suicidal ideation was ongoing, she had been hospitalized numerous times, and she admitted to struggling with caring for her children and would hit them. A child protection investigator spoke with the mother at the hospital, and she stated the children were asleep when she took the pills, but approximately 30 minutes later, she became scared and woke up her husband, who called 911. The mother stated she hoped the maternal half-siblings' father would help in caring for the children, because she could not handle the children anymore, and the child protection investigator discussed placing the children with a family member or friend until the mother could stabilize on her medication. The child protection investigator spoke with the maternal half-siblings' father who agreed to assume full time care of his children, and the child protection investigator instructed him to go to family court and obtain a custody order. The child protection investigator also observed the children, and the then 10-year-old maternal half-sibling stated she felt safe at her father's home, but not at her mother's residence. The 6-year-old's father had already been granted full custody and legal guardianship of the child, despite the 6-year-old and the father living in the home with the mother. The child protection investigator assessed the children as safe since they would be staying with their fathers and did not know about their mother's overdose. It was recommended that the family be referred for intact family services. An intact family services referral form noted that the mother had on going mental health issues and disclosed she could not care for her children. The form further stated that because the 6-year-old and his father lived in the same home as the mother, they required daycare and other services to help the mother with her mental health issues. The mother was open to receiving intact services and agreed to sign a consent for release of information for her mental health records. While the child protection investigation was still pending, the mother was arrested for driving under the influence of alcohol, but the child protection supervisor noted none of the children were in the car. Two days after the mother's arrest, the Department unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect, citing the children were asleep during the overdose and currently resided with their fathers. An intact family services case was not opened.

Ten months later, the Hotline received a report that the mother was often under the influence while the child was in her care. The reporter alleged the child's father was aware of this but continued to leave the 7-year-old child with the mother when he worked. It was also reported that the 8-year-old and 11-year-old maternal half-siblings would visit the mother, and she would sleep or was intoxicated while the children went outside without adult supervision. The child protection investigator spoke to the mother and father, who denied the allegations and stated that the mother had mostly stopped consuming alcohol since her arrest. The mother reported she regularly attended counseling and listed the medications she was taking, reporting none of them made her drowsy. The father confirmed the medications did not affect her functioning and added he would not leave the children in her care if she was impaired. The parents also denied the use of physical discipline. The father signed

the release of information form to allow the child protection investigator to access the child's records, and the mother signed the release of information form to release her own medical and mental health records. However, OIG investigators found no indication that the records were requested. The maternal half-siblings' father told the child protection investigator that he had custody of his children, but they visited their mother on the weekends, and he denied having concerns while his daughters were with their mother. The child protection investigator observed the maternal half-siblings to be in good health with no injuries. They separately reported they felt safe visiting their mother and denied she used physical discipline or left them unsupervised. The 7-year-old child was staying with fictive kin for the summer and reported to the child protection investigator that he was not afraid of his father, but he would rather live with the fictive kin because his mother would hit him. The child also stated the mother tried to drown him in the bathtub and believed this happened when he was 4 years old. When the Department initiated the child protection investigation, the mother offered to take a toxicology screening to prove she did not use illegal drugs, but it took over a month for the child protection investigator to refer her for a toxicology screening, for which she tested negative. The child protection investigator contacted the mother's current counselor, who reported the mother's regular counselor was on maternity leave. The counselor reported the mother's prognosis was fair, but it would be better if she did not continue to use alcohol. The counselor also stated the mother was recently in an intensive residential rehabilitation program for a few weeks, but she left the program early. Additionally, the child protection investigator spoke to the maternal grandmother who reported the child would be better off in the care of the fictive kin. The paternal grandmother also reported concerns to the child protection investigator, stating she saw bruises on the child, and he disclosed the mother attempted to drown him in the bathtub. The paternal grandmother added she asked the father to move in with her to get the child out of the home with the mother. The Department unfounded the investigation with a referral for community-based services, citing the mother denied the allegation, passed the toxicology screening, and was in counseling. Both the child protection investigator and supervisor no longer worked for the Department at the time this report was issued. The child's death was reported to the Hotline less than five months after the child protection investigation was unfounded.

In both investigations following the mother's psychiatric hospitalization admissions, the Department unfounded the mother, citing evidence that focused on the factors surrounding mother's suicide attempts rather than the actual risk her behavior created. In both incidents, it was reasoned that the children did not know of her attempts, but child protection staff failed to recognize that the children were still under the care of an impaired parent. It was also concerning that both child protection investigators knew that the mother was receiving mental health services, yet these records were never obtained, despite the mother signing the consent form. The gathering of information is critical to any assessment of child safety. When child protection investigators learn that a caregiver may have a mental health issue, child protection staff are required by Department procedures to obtain any mental health records. The procedures also direct staff to refer to the CFS 440-12, *Investigation/Intact Parental Mental Health Case Matrix* to be used as a guide to the types of information to be obtained regarding the caregivers' mental health. Additionally, in 2018 and 2021, in two previous investigations involving mothers with mental health issues, the OIG recommended that child protection staff utilize the CFS 968-90, *Questions for Mental Health Professionals*. The Department agreed to adapt the form for use by child protection investigators, however, at the time of this child's death, this recommendation had not been implemented.

RECOMMENDATIONS

1. As previously recommended in 2016 IG 2558 and 2021 IG 0018, the Department should develop a form similar to the CFS 968-90, *Questions for Mental Health Professionals* to be utilized by child protection staff when interviewing mental health professionals regarding an alleged perpetrator.

The Department agrees. In collaboration with the Clinical Division, DCFS Medical Director, and Child Protection Division, Policy Transmittal 2022.11, *Procedures 300.50,* was issued on September 27, 2022, to inform staff that effective immediately Procedure 300.50, *Investigative Process*, and form CFS968-90,

Questions for Mental Health Professionals have been amended. The form can now be used by the divisions of child protection, intact family services and permanency.

2. The Department should consider developing a guide for child protection staff to address deficiencies identified in child protection investigations in which parental mental health was identified. The guide should remind staff of the procedural requirements to obtain mental health records and interview treatment providers, as well as direction on the use of the mental health matrix and the revised CFS 968-90 form. Once developed, the guide should be discussed at regional meetings with child protection staff.

The Department agrees. In collaboration with the Clinical Division, DCFS Medical Director, and Child Protection Division, Policy Transmittal 2022.11, *Procedures 300.50,* was issued on September 27, 2022, to inform staff that effective immediately Procedure 300.50, *Investigative Process*, and form CFS968-90, *Questions for Mental Health Professionals* have been amended. The form can now be used by the divisions of child protection, intact family services and permanency. The form now includes a section for household members and their relationship to the client; a section to identify any tests, assessments, or evaluations the client has taken and a request to receive the client's most recent mental health assessment, psychiatric evaluation, psychological evaluation, and treatment plan; and sections to gather referral, medication, additional treatment plan and provider credential information. The amended changes to Procedures 300.50, *Investigative Process* and CFS 968-90 was communicated across child protection teams statewide.

3. Department should designate clinical consultants with expertise in mental health who caseworkers, supervisors, and child protection investigators can access for assistance, education, and information. The availability of clinical consultants as a resource should be communicated to child protection staff.

The Department agrees. The recommendation will be incorporated in the Department's redesign of the Clinical Division. The anticipated completion date is July 2023.

4. The Department should review the death investigation to determine if a more appropriate finding would be to indicate the mother for death by abuse.

The Department agrees that the more appropriate finding would have been to indicate the mother for death by abuse. The investigation was reviewed as a learning opportunity with the field. The Department will utilize this case in ongoing trainings.

DEATH AND SERIOUS INJURY INVESTIGATION 9

SERIOUS INJURY

A 28-year-old mother pushed her 5-year-old child from the 6th floor of a parking garage, and then jumped herself. The mother and child survived the fall, but the child sustained severe injuries that included extensive skull and facial fractures, traumatic brain injury, bilateral upper extremity fractures, cervical spine injury, and internal injuries. The Department indicated the mother for head injuries, bone fractures, other physical injuries, and substantial risk of physical injury by neglect. The mother was criminally charged with aggravated battery to a child. In the year prior to the serious injury, the Department had unfounded two child protection investigations involving the family, and at the time of the serious injury, there were two pending child protection investigations involving the family.

INVESTIGATION

The family first came to the attention of the Department in 2016 with a report to the Hotline of drug use by the child's father, and again in 2017 with reports of drug use

by the mother. Both child protection investigations were unfounded. The parents separated in 2018 and shared custody of their child.

In 2019, two years prior to the child's serious injury, the Department initiated a child protection investigation after the mother was psychiatrically hospitalized with suicidal ideation, and she stated she had thoughts of killing the then 3-year-old child. The reporter stated the mother subsequently denied she would harm the child and noted that the maternal grandmother and the father were caring for the child during the mother's hospitalization. The child protection investigator went to the maternal grandmother's residence on the same day of Hotline report, but no one answered the door. The child protection investigator also contacted the reporter. During their OIG interview, the child protection investigator stated she could not recall if she discussed anything with the reporter beyond confirming the Hotline report. That same day, a parallel child protection investigator interviewed the mother at the hospital. The mother stated she was taking her medication, feeling fine, and would be discharged the following day. The mother added she had a case manager from a private agency where she was receiving services. The mother stated she did not need any additional services and refused to sign the consent forms to release her information to the Department. The primary child protection investigator told OIG investigators that she did not interview the mother's case manager and did not know what services the mother was receiving.

During the child protection investigation, child protection staff did not interview medical or mental health providers, nor did they obtain the mother's mental health records, which documented a significant history of mental health concerns. In the six months prior to the 2019 Hotline call, the mother was psychiatrically hospitalized 11 times, and she had been discharged from a short-term intensive outpatient treatment program after arriving visibly high on marijuana on multiple occasions. The records noted the hospital discharged the mother the day after she spoke to the parallel child protection investigator and was scheduled for a follow-up appointment less than two weeks later, but she did not attend the appointment.

The primary child protection investigator attempted to see the child and mother at the residence the day of the mother's discharge, but they were not home. The mother and maternal grandmother returned the call, reported they were leaving for a two-week vacation and agreed to contact the child protection investigator when they returned. Three weeks after the Hotline call, the child protection investigator met with the child for the first time and noted she was free of observable signs of abuse or neglect. The mother told the child protection investigator she was psychiatrically hospitalized due to being stressed and denied she made a statement about harming her child. The mother reported she had been meeting with her therapist for approximately six months, was prescribed psychiatric medication, and denied substance use. The maternal grandmother told the child protection investigator that she had no concerns about the mother's parenting and stated the child stayed with her father after the mother's hospital admission. OIG investigators found no evidence that the father was contacted during this investigation, and the child protection investigator could not recall if he was interviewed. Less than one month after the child protection investigation was initiated, the Department unfounded the investigation.

Seven months later, the Hotline received a report that the father used heroin in the presence of his 4-year-old child and had been arrested for possession of heroin. A parallel child protection investigator saw the child the next day while she was visiting her father at a relative's home. The child protection investigator noted the child was without injury and appeared bonded to her father. The father told the child protection investigator that the mother had been violating their custody agreement and occasionally denied him access to the child. The father reported the mother had a history of mental health issues and frequent psychiatric hospitalizations, and she did not comply with her medication or treatment. The father acknowledged prior drug use and treatment. He admitted he was arrested for heroin possession the previous month and was out on bond. The child protection investigator requested he submit to a toxicology screening, but the father refused. The child protection investigator also attempted to see the child at the mother's residence, but she refused to cooperate. Days later, the child protection investigator observed the child at the father's residence, and the child reported she felt safe

with both parents. The child protection investigator observed no signs of environmental neglect or substance use in the residence. Two months after the Hotline call, the Department unfounded the investigation.

Less than three months later, the Hotline received another report that the father was using substances in the presence of the child. Two days into the Department's investigation, the Hotline received a report that police responded to the mother's home due to a disagreement between the parents over the visitation agreement. The mother told police she had the father's visitation rights revoked and reported the child was holding bags of heroin when the child was at her father's home. The Hotline call was taken as related information to the pending child protection investigation. The child protection investigator observed the child at the mother's home, and the child reported feeling safe in the homes of both parents. The child protection investigator also interviewed the father, who admitted he had relapsed but had not used substances in the months since then. The father shared that the mother obtained an emergency cease of his visitation, but the judge overturned it and ordered supervised visitation, which the paternal grandfather agreed to supervise. The judge additionally ordered the father to complete a toxicology screening, and the father agreed to share his results with the child protection investigator. The father's toxicology screening was negative, and after his prior arrest, the court ordered the father to participate in substance use disorder services and random toxicology screenings. The Department unfounded the investigation.

Less than two months later, the Hotline received a report that the father was under the influence of heroin while caring for his child on multiple occasions. The child protection investigator made multiple attempts to the see the child at both the mother and father's homes, but the mother was uncooperative, and the father did not respond. Three weeks later, while the prior investigation was pending, the Department initiated another investigation after receiving a report that the father was high on heroin while the child was in his care. The same child protection investigator went to the mother's residence to see the child that same day, but the mother became upset when the child protection investigator arrived. The mother initially denied access to the child, but eventually allowed the child protection investigator to see the child through the glass door. The mother refused to allow more contact and closed the door on the child protection investigator.

Approximately three weeks after the last call to the Hotline, the mother pushed the child from the sixth floor of a parking garage and then jumped herself. The Department indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect; cuts, bruises, welts, abrasions, and oral injuries by abuse; head injuries by abuse; and bone fractures by abuse. Following the child's serious injury, the Department indicated the father in both pending child protection investigations for substantial risk of physical injury/environment injurious to health and welfare by neglect.

In the 2019 investigation, the child protection investigator and supervisor failed to interview the child's father, see the child in a timely manner, or verify the mother's compliance with her medication and mental health treatment. DCFS Procedures 300.50(c)(6)(D), *Obtain Any Mental Health Records of Parents/Caregivers*, states if a parent refuses to sign a consent form, the child protection investigator shall request an administrative subpoena for the records within two business days of the refusal. DCFS Procedures further require that if a child protection investigator finds, during an investigation, that a family member was admitted to a psychiatric facility, the child protection investigator shall obtain any information that could impact the child's safety from the facility's staff. The child protection investigator is also required to participate in any discharge planning and recommendations and shall follow-up with community providers identified during the staffing. The Procedures directs staff to CFS 440-12, *Investigation/Intact Parental Mental Health Case Matrix* to be used as a guide to the types of information to be obtained regarding caregivers' mental health. The child protection supervisor of the 2019 investigation told OIG investigators that she had never seen the case matrix prior to speaking with the OIG. Had the child protection staff used the matrix, it would have assisted in obtaining the mother's full mental health history, as well as assessing her mental health functioning and future service needs.

In September 2018 and June 2021, in two investigations that involved mothers with mental health issues, the OIG previously recommended that child protection staff utilize the CFS 968-90, *Questions for Mental Health Professionals*. The Department agreed to adapt the form for use by child protection staff; however, at the time of this report, this recommendation had not been implemented.

RECOMMENDATIONS

1. As previously recommended in 2016 IG 2558 and 2021 IG 0018, the Department should develop a form similar to the CFS 968-90, *Questions for Mental Health Professionals* to be utilized by child protection staff when interviewing mental health professionals regarding an alleged perpetrator.

The Department agrees. In collaboration with the Clinical Division, DCFS Medical Director, and Child Protection Division, Policy Transmittal 2022.11, *Procedures 300.50,* was issued on September 27, 2022, to inform staff that effective immediately Procedure 300.50, *Investigative Process*, and form CFS968-90, *Questions for Mental Health Professionals* have been amended. The form can now be used by the divisions of child protection, intact family services and permanency.

2. The Department should consider developing a guide to address deficiencies identified in child protection investigations in which parental mental health was identified. The guide should remind staff of the procedural requirements to obtain mental health records and interview treatment providers, as well as direction on the use of the mental health matrix and the revised CFS 968-90 form. Once developed the guide should be discussed at regional meetings with child protection staff.

The Department agrees. In collaboration with the Clinical Division, DCFS Medical Director, and Child Protection Division, Policy Transmittal 2022.11, *Procedures 300.50,* was issued on September 27, 2022, to inform staff that effective immediately Procedure 300.50, *Investigative Process*, and form CFS968-90, *Questions for Mental Health Professionals* have been amended. The form can now be used by the divisions of child protection, intact family services and permanency. The form now includes a section for household members and their relationship to the client; a section to identify any tests, assessments, or evaluations the client has taken and a request to receive the client's most recent mental health assessment, psychiatric evaluation, psychological evaluation, and treatment plan; and sections to gather referral, medication, additional treatment plan and provider credential information. The amended changes to Procedures 300.50, *Investigative Process* and CFS 968-90 was communicated across child protection teams statewide.

3. The child protection investigator of the 2019 investigation should be disciplined for failure to interview the father, see the child in a timely manner, and obtain mental health records during the course of the investigation.

The Department agrees. The child protection investigator will be disciplined.

4. The child protection supervisor of the 2019 investigation should be disciplined for failing to ensure that the father was interviewed, the child was seen in a timely manner, and mental health records were obtained during the course of the investigation.

The Department agrees. The child protection supervisor will be disciplined.

DEATH AND SERIOUS INJURY INVESTIGATION 10

DEATH

The stepmother found the 14-year-old hanging from a jump rope in her closet. At the time of her death, the teen lived with her father and stepmother, who had an open placement case.

INVESTIGATION

The Department first became involved with the teen in 2012, after receiving a report that the father pulled the hair of the teen, who was then 5 years old, during a family therapy session. The Department unfounded the investigation. In December 2015, it was reported to the Hotline that the father gave a black eye and cigarette burn to the teen, who was then 9 years old. The father told the child protection investigator that he struck the teen in the face after she threatened to swallow pills to kill herself, and he accidently burned her with a cigarette while she played on the sofa several months earlier. The stepmother corroborated his statements, and the teen reported both incidents were accidental but denied she made the suicidal statement. The father also stated the teen had a mental health disorder and did not take her medication as prescribed, and he stopped taking medication for his mental health disorders but agreed to speak with his doctor about re-starting his psychotropic medication. The father denied he would harm his family, and the stepmother reported she could recognize when he was about to go into a rage, stating she would leave with the teen and the teen's 9-year-old and 20-month-old stepsiblings. However, in January 2016, the father called the child protection investigator to request the removal of the teen from his care, as he feared his anger would cause him to harm her. The child protection investigator went to the home with police and informed the stepmother that she needed to leave with the children due to the risk posed by the father. The stepmother refused to leave, the couple argued, and the father threatened to choke the stepmother. The Department took protective custody of the three children and subsequently released the teen to the care of her mother with court-ordered intact family services. The court granted the Department temporary custody of the two stepsiblings, and the Department placed them in foster care, opened a placement case, and indicated the child protection investigation.

The intact worker documented the mother's history of domestic violence, substance use, and mental health disorders. The teen began trauma therapy to address her mental health diagnosis. The court closed the mother's intact family services case in May 2016, and the caseworker assessed the teen as safe in her mother's care.

One year later, the mother brought the then 10-year-old teen to a DCFS office because the mother planned to move out of state with her paramour, without the teen. The mother stated the teen had mental health issues, including a prior suicide attempt. The mother also reported her own mental illness, that included a major mental illness and a personality disorder, hindered her ability to care for her daughter. The mother reported she planned to take the teen to her father, who continued to have an open placement case with the stepsiblings. The Department took protective custody of the teen in June 2017, placed her in a traditional foster home, indicated the mother, and the mother then surrendered her parental rights to the teen. Throughout the remainder of teen's case, she participated in weekly intensive placement services, where she received counseling, group therapy, and medication management.

During the father and stepmother's open placement case, they participated in parenting classes, received individual and couples counseling, completed a parenting group for children with mental health issues, and received monitoring of their psychotropic medications. Throughout 2018, the teen's visits with her father and stepmother were increased, and in December 2018, the court returned the teen to her father and stepmother. The next year, the court returned the two stepsiblings to the father and stepmother, and they participated in aftercare services for three months until the case closed in May 2019.

In July 2019, the Hotline received a call after police conducted a child welfare check following a report that the father allegedly was verbally abusive and kicked the then 12-year-old teen out of the home, which had multiple environmental issues, including an insect infestation, and lacked food. The police observed no infestation and the home had sufficient food. The teen had been staying with another individual for the last five days, and the

father told law enforcement he would sign guardianship of the teen over to the individual since the teen had been "difficult." The Department took no further action.

The Department initiated a child protection investigation in October 2019, after police responded to a report that the teen's stepfather sent inappropriate, sexually graphic text messages to the then 12-year-old teen. The child protection investigator spoke with the father, who no longer allowed the teen to visit her mother due the text messages. The father told the child protection investigator that the teen was mentally ill and had a history self-injury, and he had difficulty meeting her needs due to his own mental illness. The teen reported she got along well with her father and reported not wanting to have contact with her mother since she chose to remain with the stepfather. The police charged the stepfather with indecent solicitation of a child and a predatory charge a class 4 felony. The Department indicated the stepfather for sexual exploitation and indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect.

In December 2019, the Department investigated allegations of environmental neglect in the father and stepmother's home. The child protection investigator noted the 5-year-old and 13-year-old stepsiblings appeared to be clean and well cared for, and they stated they felt safe in the home. The child protection investigator also observed the home had no infestations nor environmental hazards. The teen did not engage with the child protection investigator. The father explained the teen had difficulty with being bullied, and he spoke to the school staff about it. The school staff told the child protection investigator that they developed a plan for the teen to identify staff for her to talk with as needed, after she required psychiatric hospitalization in October 2019 for cutting herself. The school reported she also received mental health services. The investigation was unfounded.

In August 2020, a child protection investigation was initiated after the 6-year-old stepsibling came to the emergency department with severe neck bruising, stating her father's paramour choked her. The stepmother told the child protection investigator that the 6-year-old sustained the injuries while visiting with her father, who lived in the same building as their family. The teen's stepmother moved the stepsiblings to stay with their maternal grandmother and stated the teen stayed away from the stepsiblings' father and his paramour, as she did not like them. The child protection investigator, however, did not interview nor assess the teen during this investigation. Police charged the paramour with aggravated domestic battery/strangulation to a child under 13, and an order of protection prohibited the paramour having contact with the 6-year-old. The stepsiblings' father was indicated for inadequate supervision and the paramour for cuts, bruises, welts, abrasions, and oral injuries. One month into the pending child protection investigation, the court ordered the stepmother to participate in intact family services. The intact family case, assigned to a private agency, listed the members in the case as the stepmother, father, two stepsiblings, and the stepsiblings' father. The then 13-year-old teen was not included as a case member as the father reported she lived elsewhere, and the father and stepmother moved out of the building.

While the child protection investigation of injuries to the 6-year-old stepsibling was pending, the Hotline received a report that the father dropped off the teen at a fictive kin's home one month earlier due to housing instability. According to the reporter, the father told the fictive kin to obtain temporary guardianship of the teen through court, but then the father did not attend court, and he wanted the teen returned to his home. The reporter also expressed concerns about the father's mental health disorders, noncompliance with medication, and history of violence. The Hotline worker determined the report did not meet criteria for further action as the reporter did not provide information that the father could not care for his daughter, he made an alternative living arrangement for her, and he retained guardianship of the teen with the right to custody. The supervisor of the family's intact family services case, which opened one day after the Hotline call, reported to OIG investigators that they did not know about this report to the Hotline. The same day of Hotline call, the fictive kin filed an emergency order of protection, which the court granted. This provided the fictive kin with physical custody of the teen, as the petition stated the father had been violent towards the teen and kicked her out of the home. Less than three weeks later, the father and fictive kin attended court for the plenary order, and the court closed the case as the

order was voluntarily dismissed. At that time, the fictive kin filed a petition for guardianship of the teen, which the court dismissed the following week, as the fictive kin failed to attend the court date.

During the open intact family services case, about one week before the plenary hearing, the father and stepmother reported parenting the teen as part of the interviews for the integrated assessment. Almost two weeks later, the intact worker visited the maternal grandmother's home and met with the father, stepmother and two stepsiblings. The teen was not mentioned. The parents reported they lived in their van and occasionally stayed with the maternal grandmother or the maternal uncle. The following week, the intact supervisor and worker attended a court hearing, where the judge awarded the Department temporary custody of the two stepsiblings due to concerns about the father's mental health and housing issues. The intact supervisor reported that while at the courthouse, the father asked why the court left the teen in his care but removed his stepchildren. The intact supervisor told OIG investigators that she did not know the teen was in her father's care prior to this court date and reported the ASA and the Guardian ad Litem (GAL) also learned of this during the court date. The intact supervisor stated she asked the GAL if she should call the Hotline about the teen being in his care, but the GAL stated a petition would be filed separately for the teen, so she did not need to contact the Hotline. The GAL told OIG investigators she did not dissuade the intact supervisor from calling the Hotline. The GAL reported she discussed the situation with the ASA, and they agreed the teen should enter care, but they could not proceed for shelter care that day since the teen did not have an open court case. The GAL stated she did not follow up to ensure the ASA filed the petition. No petition was filed for the teen prior to her death, which occurred two months later. OIG investigators interviewed the Department legal staff assigned to that region, who reported the teen was not included as a member of the court case because she was not included in the child protection investigator's statement of facts from the August 2020 investigation. At the time of the court hearing, Department legal staff believed the teen was not a member of the household and could not recall when the teen began living with her father again.

The private agency transferred the family to a placement worker and assigned the same supervisor to oversee the case. Four weeks after the court hearing, the stepmother asked during a phone call with the supervisor and placement worker if the teen could attend the parent/child visits with the stepsiblings, and the supervisor approved for her to attend some visits. Throughout the remainder of the placement case, there was no evidence that the worker nor the supervisor obtained additional information about teen's living arrangements nor discussed her safety and well-being. Eleven days before the teen's death, the worker met with the father and stepmother in their home but noted no indication of the teen during this visit.

RECOMMENDATIONS

1. This report should be shared with the Department's Office of Legal Services.

The Department agrees. The Report was shared with the Office of Legal Services.

2. This report should be shared with the Deputy Director of the State Central Register.

The Department agrees. The report was shared with the Deputy Director of the State Central Register.

3. This report should be shared with the private agency involved in the family's intact and placement services case.

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

4. This report should be shared with the involved State's Attorney's Office.

The Department agrees. The OIG shared the report with the involved State's Attorney's Office.

5. This report should be shared with the involved GAL.

The Department agrees. The OIG shared the report with the involved GAL.

6. This report should be shared with the Chief Judge of the Juvenile Division where the family resided.

The Department agrees. The OIG shared the report with the Chief Judge.

DEATH AND SERIOUS INJURY INVESTIGATION 11

DEATH

A 12-year-old was admitted to the emergency department for gastrointestinal issues, including abdominal pain, constipation, and fecal impaction. The next day, the child went into cardiac arrest during emergency surgery for an intestinal perforation and was pronounced deceased. The medical examiner determined the death was caused by perforation of the cecum due to complications of chronic constipation and reported the manner of death as natural. The Department unfounded the mother for allegations of death by neglect to the child and substantial risk of physical injury/environment injurious to health and welfare by neglect to the child's three siblings. In the year prior to the child's death, there was an unfounded child protection investigation involving the family.

INVESTIGATION

Between 2012 and 2017, the Department conducted three child protection investigations and unfounded the child's parents in all three investigations, which involved allegations of cuts, bruises, welts, and medical neglect.

In October 2018, the Department initiated a child protection investigation after receiving a report that the then 9-year-old child had gastrointestinal issues that affected her schooling, which included soiling herself, crying spells, and angry outbursts. The reporter told the Hotline that the child disclosed her mother did not provide her with medication which resulted in difficulty sleeping due to the pain. A child protection investigator interviewed the child, who confirmed she experienced frequent constipation and did not always take her medication, resulting in a painful buildup in her stomach. The child protection investigator then spoke to the mother, who denied failing to give the child her medication, reporting she gave her a fiber supplement, but it took several days to become effective. The mother stated that after the child's previous hospitalization for gastrointestinal issues, the doctors instructed her to give the child a specific over the counter laxative for future constipation. The child protection investigator contacted the child's primary care provider, and the nurse reported the child was first seen in January 2017 for chronic constipation, and the doctor recommended the laxative and to follow-up with a gastrointestinal specialist. The nurse stated the child required hospitalization in March 2017 at a different medical center, and at discharge, staff instructed the mother to follow-up with the gastrointestinal clinic. Almost two months after initiating the investigation, the child protection investigator followed up with the child, who reported she felt better and had not needed her medication lately. The next day, the child protection supervisor agreed there was insufficient evidence to indicate the mother for medical neglect, and the Department closed the investigation. There was no documentation that the child protection investigator requested the child's medical records or contacted the medical center where the child was hospitalized. The OIG obtained the medical records, which documented the mother did not ensure that the child received appropriate follow-up care or take her medication as prescribed.

Less than three weeks later, in December 2018, the Department initiated a child protection investigation after receiving a report that the child's then 13-year-old sibling frequently complained of arthritis pain at school. The reporter stated the sibling's juvenile arthritis required infusions every three months and weekly injections, but the sibling disclosed her last infusion occurred 10 months earlier. The reporter also had concerns about the child experiencing pain from her gastrointestinal issues, causing frequent school absences. The child told the child protection investigator that her stomach felt better and did not remember the last time she took her medicine.

The 13-year-old sibling reported she had not received her arthritis injections for months, causing her to experience pain and miss school. The mother informed the child protection investigator that the sibling's treatment required regular blood tests, and hospital staff would notify her after the test results to approve the injection. The mother stated the sibling had a blood test three months ago, but she never heard from the hospital. The mother stated her insurance lapsed the previous week, and she planned to follow-up with the public aid office and obtain medical appointments for her children. The child protection investigator followed up with the children two months later, and the 13-year-old sibling reported she continued to experience pain because she had not seen her doctor and her injections expired. The child denied recent constipation and could not recall the last time she saw her doctor. The mother declined a referral for intact family services and stated she had not made any appointments because the medical card application had been delayed, but she agreed to schedule medical appointments that day. The child protection investigator contacted the hospital and confirmed the mother scheduled the sibling's appointment. Hospital staff reported the sibling had not had infusions for nearly a year and failure to treat the sibling's significant arthritis would be considered medical neglect. The hospital staff stated a lack of insurance would not be a reason for not seeking treatment as the hospital had resources to assist patients. The supervisor instructed the child protection investigator to obtain the medical records, who then sent requests to the hospital and primary care provider. However, the investigation closed two days later, prior to receipt of medical records. The Department indicated the mother for medical neglect of the 13-year-old sibling, because she failed to ensure the sibling received her treatment. The Department unfounded the mother for medical neglect of the child, reasoning the child stated she felt better.

Approximately 10 months later, in January 2020, the Department initiated an investigation, after receiving a report that the then 11-year-old child had visible tooth decay and reported tooth pain. The reporter stated school staff attempted to assist the mother in obtaining dental care, but she did not return the school's calls. The reporter also had concerns about the mother's ability to manage the child's gastrointestinal issues as the child recently required hospitalization for an intestinal blockage. The same day as the Hotline report, an on-call child protection investigator attempted to see the family with no success. Less than one week later, the Hotline received a related information call, stating the child had not taken her prescribed daily laxative since her discharge from the hospital the prior week. The reporter stated the child complained at school of abdominal pain, which the medicine would have helped. During the pending investigation, child protection staff did not address information contained in the related information call, including investigating the mother's reported failure to administer the child's medicine.

The child protection investigator did not see the family until almost two months after the investigation opened, and in an interview with the OIG, the child protection investigator could not explain the delay in seeing the children. Once the child protection investigator saw the family, the mother stated she took the child to the dentist, but the child required a referral to a specialist due to her fear of the dentist and refusal to be examined. The child did not see the specialist because the office closed in response to the pandemic. The child confirmed this information and showed the child protection investigator her tooth, stating it no longer hurt. The mother also reported the child was hospitalized for gastrointestinal issues but did not have treatment or discharge documentation. The mother reported she gave the child the laxative, and the child told the child protection investigator she felt better. That same day, the child protection investigator requested the child's hospital records; however, the investigation file did not contain the medical records. The next day, the child protection investigator contacted the dental provider, who confirmed the child's referral, but the child protection investigator never spoke with the specialist because their office remained closed due to the pandemic.

Two months after the report to the Hotline, the Department closed the investigation and unfounded the mother for medical neglect, citing insufficient evidence to support the allegations. The supervisor approved contact waivers for both reporters, the primary care provider, the school, and collateral contacts. The child protection investigator only documented performing investigative duties for the last two days of the investigation. In an interview with the OIG, the child protection supervisor reported being unaware of the delay in seeing the family

and that the child protection investigator should have requested the medical records at the onset of the investigation instead of the day before its closure. The supervisor reported not considering an extension for the investigation as the supervisor did not believe additional information would change the final finding. The supervisor told OIG investigators that she considered the gastrointestinal issues, but the mother reported giving the child the laxative and focused the investigation on the reported dental issues. The supervisor also stated that medical neglect related to the gastrointestinal issues was not appropriate because a medical provider never contacted the Hotline, and the child had been discharged from the hospital during the investigation. Lastly, the supervisor stated if the focus had been on the gastrointestinal issues, she would have considered a DCFS Nurse referral but did not think a nursing referral was appropriate for dental care.

Four months later, the Department initiated another investigation after receiving a report that the then 11-year-old child and her siblings missed a significant amount of school, and the child could not attend until she had an up-to-date physical. The reporter alleged the then 15-year-old sibling was not receiving arthritis treatment. The same day of the Hotline report, the child protection investigator contacted the school, who confirmed the child and her siblings frequently missed school. The next day, the child protection investigator visited the home, and the mother reported she scheduled a physical for the child and gave her herbal supplements for her gastrointestinal issues. The child protection supervisor instructed the child protection investigator to complete a nursing referral, request medical records, and ask the children's physicians about possible medical neglect. The child protection investigator contacted a hospital worker, who stated the adolescent sibling had not received arthritis treatment in in seven months. The child protection investigator also spoke with the child's primary care provider, who reported the child had a history of constipation, was prescribed the over- the-counter laxative, and was referred to a gastroenterologist over six months earlier. The provider did not know if the specialist had seen the child. In the OIG interview, the child protection investigator stated the children's medical providers did not voice a concern regarding medical neglect, but the child protection investigator could not recall specifically asking about medical neglect. The child protection investigator told OIG investigators that she did not discuss the mother's decision to substitute herbal supplements for the prescribed laxative, nor did she interview the gastrointestinal specialist. After speaking with providers, the child protection investigator instructed the mother to immediately ensure the 15-year-old sibling received care for her arthritis and all the children needed to be seen by the primary care provider. The next week, Department staff requested hospital records, but the hospital reported not having records for the requested timeframe. The investigation was granted an extension after the child protection investigator went on unplanned sick leave, returning to work approximately four months later. The child protection investigator stated in the OIG interview that due to her illness, she was unable to conduct investigative activities, but she attempted to make a DCFS Nurse referral and had difficulty with the electronic submission. A month into the child protection investigator's sick leave, the supervisor was instructed to finish the child protection investigator's 29 pending investigations in the next four weeks, but the supervisor's overtime request for her team was denied. A parallel child protection investigator visited the family, and the mother reported she followed through in taking her children to the primary care provider, and the doctor changed the 15-year-old sibling's treatment to an injection every six months. The child also showed the child protection investigator her herbal supplements and mineral oil for her gastrointestinal issues. Citing insufficient evidence, the Department unfounded the mother for medical neglect to the sibling and substantial risk of physical injury/environment injurious to health and welfare by neglect to the children. In the OIG interview, the supervisor stated she did not add an allegation of medical neglect to the child, because they did not obtain information to support the allegation. The supervisor explained the child's doctor reported requiring the child to take a laxative and mineral oil, which were not prescriptions, and although there was an issue with the child taking her medication, there were no reports that this rose to the level of abuse or neglect, and the child's medical providers never reported concerns about medical neglect to the child. However, staff never asked the treating physicians about possible medical neglect. Failure to obtain information from the treating providers led to child protection staff making the decision about the presence of medical neglect, a decision they do not have the expertise to make.

Seven months later, the Department received notification of the child's death after she experienced cardiac arrest during an intestinal perforation surgery. The Department took protective custody of the child's three siblings and placed them with a maternal relative. The assistant state's attorney rejected the Department's petition for custody, citing the parents had shared custody and there was no prior court involvement that prohibited the children from living with their father. The Department returned the children to the mother after she agreed to participate in intact family services. During the investigation, the child's surgeon stated the buildup of fecal matter in the bowel caused a perforation and infection spread very quickly through her adnominal cavity. The surgeon reported typical treatment for the child's condition required regular follow up with primary care and specialists and would also include laxatives and stool softeners. The Department unfounded the mother for death by neglect to the child because the mother brought her to the hospital when she was in pain. The Department did not include a medical neglect allegation of the child during the investigation.

The OIG obtained and reviewed the child's medical records, which had not been obtained by Department staff throughout the family's involvement. The medical records showed the mother's history of failing to follow through with the child's recommended medical care, including specialist care and medication regimen. The child protection staff appeared to minimize the risk associated with the child's illness, and investigations into medical neglect can be nuanced and require an expertise to evaluate medical information. Department offers DCFS Nurses as a resource for direct line staff, however child protection staff did not consult the nurses during any of the family's pending investigation. DCFS Procedure 300 Appendix B- #79 Medical Neglect does not include guidance for using DCFS Nurses in investigating allegations of medical neglect. There is also limited guidance in completing the CSF 531 DCFS Regional Nurse Referral Form, which does not differentiate between the role of the DCFS Nurse in investigations and placement services. The errors in both 2020 child protection investigations highlight the need for the Department to increase guidance and training on when and how to utilize DCFS Nurse referrals in child protection investigations.

After learning of the child's death, the Department placed the primary child protection staff involved in the 2020 child protection investigations on desk duty, which left vacancies in the same field office for over nine months. After tragic events, a review of work leading up to the child's death is warranted, but the Department should critically evaluate the use of long-term desk duty so as to not strain direct line staff. The Department is currently experiencing unprecedented staffing shortages and placing staff on desk duty for long periods of time without review can negatively impact the Department's ability to respond to reports of abuse and neglect.

RECOMMENDATIONS

1. The Department should discipline the child protection supervisor involved in the first 2020 investigation for failing to ensure children were seen at the outset of an investigation and failing to address information in a related information call.

The Department agrees. The employee received a 15-day suspension.

2. The Department should discipline the child protection investigator involved in the first 2020 investigation for failing to ensure children were seen at the outset of an investigation and failing to address information in a related information call.

The Department agrees. The employee received an oral reprimand.

3. The Department should share this report with the Regional Administrator and DCFS Regional Nurse to facilitate a discussion about the investigations of medical neglect with the child protection staff involved in the 2020 investigations. The discussion should include the use of DCFS Nurses, the importance of obtaining medical records and the need to obtain statements from medical providers about medical neglect.

The Department agrees. The report has been shared with Child Protection Leadership for training purposes. Policy Transmittal 2022.08, *P300.100 and CANTS 65-B* was issued to staff on September 9, 2022 to inform staff of changes to Procedure 300.100, *Medical Requirements for Reports of Child Abuse and Neglect*, and the implementation of form CANTS 65-B, *Evaluation of Medical Neglect of a Child*. The changes to Procedure 300.100 include action that Child Protection Specialists must take with regards to medical evaluations and care when investigating reports of abuse or neglect. The updates to Procedures 300 were reviewed in subregional in-person meetings with Child Protection Supervisors, Area Administrators and Regional Administrators.

4. The Department should revise Procedures 300 Appendix B Allegation #79 Medical Neglect to improve guidance on obtaining statements from medical providers about the presence of medical neglect regardless of final finding decision.

The Department agrees. The report has been shared with Child Protection Leadership for training purposes. Policy Transmittal 2022.08, *P300.100 and CANTS 65-B* was issued to staff on September 9, 2022 to inform staff of changes to Procedure 300.100, *Medical Requirements for Reports of Child Abuse and Neglect*, and the implementation of form CANTS 65-B, *Evaluation of Medical Neglect of a Child*. The changes to Procedure 300.100 include action that Child Protection Specialists must take with regards to medical evaluations and care when investigating reports of abuse or neglect. The updates to Procedures 300 were reviewed in subregional in-person meetings with Child Protection Supervisors, Area Administrators and Regional Administrators.

5. The Department should develop and implement enhanced training on investigating allegations of medical neglect and provide front line staff with the tools needed to obtain information from medical providers.

The Department agrees. The report has been shared with Child Protection Leadership for training purposes. Policy Transmittal 2022.08, *P300.100 and CANTS 65-B* was issued to staff on September 9, 2022 to inform staff of changes to Procedure 300.100, *Medical Requirements for Reports of Child Abuse and Neglect*, and the implementation of form CANTS 65-B, *Evaluation of Medical Neglect of a Child*. The changes to Procedure 300.100 include action that Child Protection Specialists must take with regards to medical evaluations and care when investigating reports of abuse or neglect. The updates to Procedures 300 were reviewed in subregional in-person meetings with Child Protection Supervisors, Area Administrators and Regional Administrators.

6. The Department should provide the field with guidance on use of DCFS Nurses during pending investigations of child abuse and neglect. The Department should review, and change as needed, the CFS 531 Regional Nurse Referral Form to include the role of DCFS Nurses in child protection investigations.

The Department agrees. In Fall 2022, Child Protection worked with Clinical and Nursing to streamline the CFS 351, Nurse Referral Form. The CFS 351 was shortened and reframed, and the Nursing division was granted access to SACWIS, to ensure access to entire case file and complete information. Nursing will document the completed consultation and ensuring record is complete. A copy of CFS 351 provides specific and separate directions for DCP vs intact and permanency. It is currently with Office of Child and Family Policy and available upon request.

7. The Department should develop written protocol for the use of restricted duty status. The Department should review the practice of placing staff on indefinite desk duty after the death of a child and explore the use of increased supportive supervision in lieu of desk duty, when appropriate.

The Department agrees. The Department is collaborating with staff, the union and across divisions to develop a written protocol related to restrictive duty status that will work effectively for various divisions and their respective job assignments. The updated protocol will be released later in FY23.

8. As previously recommended in OIG Report2021 IG 0018 (issued June 30, 2021) and agreed to by the Department, the Department should develop a referral form, similar to the CANTS 65-A, Referral Form for Medical Evaluation of a Physical Injury to a Child, that is specific to allegations of medical neglect. The OIG reiterates this recommendation and the critical need for full implementation.

The Department agrees. The report has been shared with Child Protection Leadership for training purposes. Policy Transmittal 2022.08, *P300.100 and CANTS 65-B* was issued to staff on September 9, 2022 to inform staff of changes to Procedure 300.100, *Medical Requirements for Reports of Child Abuse and Neglect*, and the implementation of form CANTS 65-B, *Evaluation of Medical Neglect of a Child*. The changes to Procedure 300.100 include action that Child Protection Specialists must take with regards to medical evaluations and care when investigating reports of abuse or neglect. The updates to Procedures 300 were reviewed in subregional in-person meetings with Child Protection Supervisors, Area Administrators and Regional Administrators.

9. As previously recommended in OIG Report 2021 IG 0018 (issued June 30, 2021) and agreed to by the Department, the Department should amend Procedures 300, Appendix B, Allegation of Harm #79-Medical Neglect to include the following required activity, "If a child has special health care needs, as defined in Procedures 302, Appendix O, Referral for Nursing Consultation Services, the Child Protection Specialist must complete a DCFS nurse referral." The OIG reiterates this recommendation and the critical need for full implementation.

The Department agrees. Allegation #79, *Medical Neglect* is in the process of being revised.

10. Child Protection management should review the death investigation to determine if a medical neglect allegation for the mother should have been added to the investigation. The decision to return the children to the mother and not engage the father should also be reviewed.

The Department agrees. The investigation was reviewed with the involved child protection staff for training purposes.

DEATH AND SERIOUS INJURY INVESTIGATION 12

DEATH

A 4-month-old was discovered by her mother unresponsive and wedged in between an adult-sized mattress and the wall. The mother called 911, and a neighbor attempted CPR prior to first responders arriving. An ambulance transported the infant to the hospital, where she was pronounced deceased. The mother admitted to smoking marijuana and consuming alcohol the night before and placing the infant on her stomach in the adult-sized bed. The mother then laid down next to the infant and fell asleep. The Department indicated the mother for death by neglect. In the four months prior to the infant's death, the mother had an open intact case, a pending child protection investigation, and two unfounded child protection investigations. See Appendix B for the full report.

INVESTIGATION

The infant's mother has an extensive history of child neglect in a different state, dating back to 2016 due to concerns regarding the mother's mental health and substance use. In 2019, the infant's then 3-year-old and 4-month-old maternal siblings were placed into that state's foster care system and a placement case was opened for the mother.

In June 2021, the mother came to Illinois. The Department initiated an investigation after learning the mother gave birth to the then 2-week-old infant, the deceased, and had a pending child investigation in the other state. The Illinois child protection investigator contacted the out-of-state child protection worker, who stated the mother had not been cooperating with her placement case services, and the case was moving towards

termination of her parental rights. The out-of-state child protection worker also reported the mother tested positive for cocaine in July 2020 and for marijuana in January 2021, and there were serious concerns for the infant's wellbeing and safety due to the mother's drug use and mental health. The Illinois child protection investigator then contacted the mother's out-of-state placement worker, who stated the mother had not been compliant with parenting services, toxicology screenings, visitations with her children, and completing a substance use evaluation. The placement worker stated the mother completed a psychological evaluation but did not follow through with mental health treatment and medication. The placement worker stated the infant would have been taken into protective custody if the mother had given birth prior to fleeing to Illinois. The worker added the mother was also on probation for assault, leading the worker to believe this was another reason the mother fled, because she did not want to deliver the infant while in jail.

The next day, the Illinois child protection investigator located the mother and infant at a shelter. The mother told the child protection investigator that she came to Illinois because there were no resources to help her in the other state. She confirmed her two older children were in foster care and said she was unable to complete her services due to transportation issues. The mother reported she completed a psychological evaluation but denied knowing that mental health treatment and medication had been recommended. She admitted to being on probation for assaulting a family member and her probation officer did not know that she was in Illinois. The mother reported working with the shelter to obtain stable housing. The child protection investigator discussed intact family services with the mother, who agreed to the services. The child protection investigator informed the mother that if she did not cooperate with intact family services, the infant might be taken into protective custody. The child protection supervisor told OIG investigators that they did not take protective custody of the infant because the shelter's staff stated the mother was doing well with the infant, and the mother agreed to cooperate with intact family services.

DCFS opened the mother's intact family services case less than two weeks after the Department initiated its investigation and assigned a Department intact worker to the case. The intact worker told OIG investigators that he spoke briefly with the mother's out-of-state placement worker but was not provided with substantial information, other than the mother's history of substance use and mental health issues. The intact worker added the Illinois child protection investigator did not provide the mother's out-of-state child welfare records; however, the child protection investigator told OIG investigators that she requested the out-of-state records but did not receive them prior to the investigation closing. The Department unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect.

The intact staff developed a service plan and tasked the mother with completing random toxicology screenings, engaging in mental health counseling, and participating in parenting services. In early July 2021, the intact worker documented the mother was engaged in domestic violence services through the shelter where she was residing, and the mother also asked the intact worker to connect her to a mental health counselor.

A week later, the intact worker returned to the shelter for a scheduled visit with the mother and the then 7-week-old infant, but shelter staff informed the worker that the mother left the shelter with the infant several days prior. The Department initiated a second child protection investigation as the mother left the shelter without notifying her intact worker nor informing the worker of the newborn's whereabouts. At that time, the intact case had been open for three weeks. A child protection investigator spoke to the intact worker, who found the infant with her maternal grandfather. The grandfather reported to the intact worker that the mother left the infant with him, the mother had been gone for a day, and he did not know her whereabouts. However, the grandfather later admitted to the child protection investigator that he lied to the intact worker and that the mother was arrested and in jail. The grandfather stated he retrieved the newborn from jail, expressing to the child protection investigator that he wanted to care for the infant. The child protection investigator observed the infant to appear healthy and had no signs of abuse or neglect. The infant was assessed as safe and the child protection investigator's supervisor documented that there was no information to suggest the mother could not be around the infant, as mother "allegedly dropped off the infant and then turned herself into jail." However, two months

later, the child protection investigator received police reports of the incident, stating the mother was arrested for domestic battery involving another woman, and the infant was present during the incident.

The next day, the grandfather called the child protection investigator, requesting assistance as the mother was released from jail and at his home, demanding to have the infant. The child protection investigator arrived at the home and observed the mother screaming at the grandfather and police were present. The child protection investigator spoke with the mother, who stated the grandfather kicked her out of the home and would not allow her to take the infant. The child protection investigator spoke with the mother about what would be best for the infant, as she had no plans for where she would go, and the mother agreed to allow the infant to remain with the grandfather for the weekend. The child protection investigator completed an oral toxicology with the mother, which was negative for all substances. The child protection investigator's supervisor instructed the child protection investigator to re-request the mother's out-of-state child welfare records to determine if protective custody should be taken. The child protection investigator told OIG investigators that it took over a month to receive the documents, as there were barriers in obtaining out-of-state records.

In mid-July 2021, four days after the second investigation was initiated, the intact worker met with the mother at a motel where she was staying. The mother reported the infant would remain with the grandfather until the mother was able to obtain stable employment and housing. However, the mother called the intact worker the next evening and stated the grandfather returned the then 8-week-old infant to the mother. The intact worker went to the hotel to observe infant, and the mother stated she had been placing the infant to sleep in her car seat, as the grandfather had the infant's bedding. The mother refused when the intact worker offered to provide her with a pack-and-play, stating she just wanted to get the pack-and-play back from the grandfather. The intact worker discussed safe sleep practices again, and the mother denied she allowed the infant to sleep in her bed with her. The intact worker retrieved the pack-and-play from the grandfather, brought it to the mother, and asked if she needed anything else, to which the mother replied she did not need anything. However, an hour later, the out-of-state placement worker notified the intact worker that during an online visit between the mother and her two older children, the placement worker observed the mother feeding the infant water, and the mother explained to the placement worker that she was out of formula.

The Department initiated a third investigation after the Hotline received a report that the mother ran out of formula for her 9-week-old infant and had no plans to obtain additional formula. The reporter stated it was unclear when the infant was last provided substantial food, as the mother disclosed that she was feeding the child water and Pedialyte until she also ran out of Pedialyte. The reporter expressed there were ongoing concerns regarding the mother and stated the child may need to be taken into protective custody.

An on-call child protection investigator contacted the intact worker, who reported the mother received WIC, but she had not made her appointments due to transportation issues. The worker added he offered to drive her, but the mother refused. The on-call child protection investigator met with the mother at the motel and provided her with formula, distilled water, diapers, and clothing. The child protection investigator prepared a bottle as the mother set up the pack-and-play, as it was still in the box from when the intact worker delivered it earlier that day. The mother reported she did not tell the intact worker she need formula because she did not want to get into trouble. The child protection investigator explained that the intact services were in place to support the mother so she could maintain custody of her infant. The child protection investigator updated her supervisor, and they assessed the infant as safe; however, the supervisor documented the infant was screaming upon the child protection investigator's arrival and was "clearly hungry and immediately took a bottle." The on-call child protection investigator told OIG investigators that she did not ask the mother how long the infant had been without formula.

The second child protection investigator was assigned to this third investigation as the second investigation was pending. The intact worker contacted the child protection investigator as he had received a message from the mother, stating she needed assistance as she was unable to pay for the motel room. The worker attempted to

contact the mother and the maternal grandfather to locate the infant, but no one responded. In early August 2021, the intact worker, child protection investigator, and their supervisors met to discuss the mother's case. After leaving the motel, the mother moved into a different shelter, but that shelter evicted her six days later due to her lack of participation in required classes. The mother moved back into the original shelter that she lived at when her intact family services case opened seven weeks prior.

The following week, the child protection investigator and intact worker met with the mother, who agreed to comply with anger management, homemaker services, and parenting classes. The mother reported she was engaging in counseling and domestic violence services through the shelter. The intact worker directed the mother to have the shelter workers contact him to confirm she was engaging in the services, and during each weekly visit, he reminded the mother to follow up on this. In early September 2021, the intact worker confronted the mother about her lack of progress with her intact services and discussed the possibility that the shelter may ask her to leave if she was not engaging in services. The worker also completed a CERAP, identified no safety threats, and assessed the 3-month-old infant as safe. The next week, the intact supervisor directed the worker to staff the case with the state's attorney's office due to the mother's lack of cooperation. The mother stopped responding to the intact worker, despite the worker's continued efforts, and service providers also reported to the worker that they had not heard from the mother. The intact worker and supervisor met again with the child protection investigator and supervisor, and reported the mother was about to be dismissed from the shelter due to noncompliance. The child protection investigator and supervisor told OIG investigators in separate interviews that although the mother was not cooperating, there was no urgent or immediate threat identified to justify taking protective custody of the infant. The child protection supervisor and intact worker both spoke of challenges with court referrals in their interviews with OIG, and it was reported the court was dealing with an especially high number of cases and referrals.

In mid-September 2021, the mother responded to the child protection investigator's ongoing attempts to contact her. The child protection investigator transported the mother and infant for a wellness exam at a prompt care, and the doctor identified no concerns regarding the infant, including her weight. The following week, the Department unfounded the mother for inadequate food and closed the third investigation. The mother's second investigation remained open, as the child protection investigator had not received the out-of-state child welfare records.

The intact worker documented additional attempts to contact the mother, but she did not respond. Two days before the child's death, the mother responded to the intact worker, sending a text message that she was out of town. The worker requested to schedule a visit for the following week so that he could see the infant, but the mother did not respond.

The Department closed the second investigation a month after the infant's death. The mother was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect.

RECOMMENDATIONS

1. The child protection investigator involved in the June 2021 investigation should receive non-disciplinary counseling. As part of the counseling session, this report should be reviewed and discussed with the child protection investigator.

The Department agrees. The report will be shared, and the child protection investigator will receive non-disciplinary counseling.

2. The child protection supervisor for the June 2021 investigation should receive non-disciplinary counseling. As part of the counseling session, this report should be reviewed and discussed with the child protection supervisor.

The Department agrees. The report will be shared, and the child protection supervisor will receive non-disciplinary counseling.

3. The child protection investigator involved in the second and third investigations should receive non-disciplinary counseling. As part of the counseling session, this report should be reviewed and discussed with the child protection investigator.

The Department agrees. The report will be shared, and the child protection investigator will receive non-disciplinary counseling.

4. The child protection supervisor for the second and third investigations should receive non-disciplinary counseling. As part of the counseling session, this report should be reviewed and discussed with the child protection supervisor.

The Department agrees. The report will be shared, and the child protection supervisor will receive non-disciplinary counseling.

5. This report should be shared with the area administer of this region to use in supervision with child protection staff.

The Department agrees. The report will be shared with the area administrator.

6. This report should be shared with the intact family services worker for training purposes.

The Department agrees. The report was shared with the intact family services worker.

7. This report should be share with the intact family services supervisor for training purposes.

The Department agrees. The report was shared with the intact family services supervisor.

8. This report will be used by OIG in Error Reduction training on decision making practices in child protection.

The Department agrees. The report was shared with OIG training staff for use in Error Reduction Training.

DEATH AND SERIOUS INJURY INVESTIGATION 13

ISSUE

During the OIG's review of complaints and child deaths from FY 20 through FY 22, the OIG identified a systemic pattern of child protection investigations with significant delays in child protection investigators making initial contact with the child(ren) in response to a Hotline call. Department Rule requires in-person contact with the alleged child victim within 24 hours of the report to the State Central Register. According to Department Procedure, when contact with alleged child victims is not made within 24 hours, good faith attempts must be made every 24 hours or sooner, including weekends and holidays, until the alleged child victim is seen, unless a waiver is granted by the child protection supervisor. DCFS Procedure 300.50(c) provides requirements for seeing children at the outset of the investigation. See Appendix A for the full report.

INVESTIGATION

OIG investigators identified 24 child protection investigations in which the child protection investigators and their supervisors failed to assess the safety of the alleged child victims in a timely manner. The timeframes of these delays ranged from just under a month to over 100 days before contact was made with the child(ren), leaving alleged victims of child abuse/neglect in unassessed

and potentially unsafe situations. The OIG's review found the delay in seeing children occurred throughout the state in investigations of both abuse and neglect allegations. The OIG found that attempts after the initial mandate occurred because of a precipitating event such as the investigation reached the 60-day mark, the Department received related information, or a child died. The OIG's review also revealed high percentages of delay in seeing children in investigations involving our most vulnerable youth:

- Eleven of the 24 (46%) investigations involved children under 1 year old.
- Twenty of the 24 (83%) investigations involved children 3 years and under, and
- Twenty-two of the 24 (92%) investigations involved children 5 years and under.

Procedurally, the importance of seeing children is evident through the extensive guidelines set forth in Procedures 300. Procedure 300.50(c), *Initiation of the Investigation*, requires that "the safety of all alleged child victims must be assessed before an investigation is considered initiated" and that the child protection specialist shall take whatever steps are necessary to obtain the current location of the alleged child victims and proceed immediately to their location. Good faith attempts must be made every 24 hours or sooner, including weekends and holidays, until the alleged child victim is seen, unless a waiver is granted by the Child Protection Supervisor. Procedures note that, "the fact that a good faith attempt was made and that the 24-hour mandate was technically met does not relieve the Child Protection Specialist of the responsibility for continuing to attempt to establish in-person contact with the alleged child victim as soon as possible."

A common barrier to seeing children can often be difficulty in locating the family. As such, the Department provides both procedural requirements and guidance in using tools to locate families. Few child protection investigators documented using a diligent search or the Integrated Eligibility System (IES), the State of Illinois's computer based public benefits application and management system. In addition, using schools and daycares as a resource to locate the family were often not utilized until later in the investigations, if at all. Police were also not called to request well-child checks in the event the investigator was unable to make contact with the family. The Department has resources such as all shift alerts and on-call workers, but these were rarely utilized. Although, in many of the child protection investigations supervisors routinely instructed investigators to continue making attempts, these directives were rarely followed and did not include a plan or strategy to eliminate barriers to seeing the children.

The investigations reviewed by the OIG are a small sample of the total number of child protection investigations completed and may not be representative of all investigations; however, this sample covered all geographic regions, indicating it could be a statewide issue, highlighting the need for Departmental review.

RECOMMENDATIONS

1. The Department should review the current status of children that have not been seen in child protection investigations within a week of the Hotline call and develop a plan to ensure that the safety of the children has been immediately assessed.

The Department agrees. In June 2022, to ensure that children brought to the attention of the Department are seen and contact is documented timely in SACWIS, the Department, in collaboration with the Department of Innovation and Technology (DOIT) created an interactive dashboard using analytics software (PowerBI). The dashboard is updated daily and provides data to the field at the statewide, regional, sub-regional, team and individual worker levels.

2. Department Administration must develop a plan to ensure that more efficient efforts are made to meet with alleged child victims at the inception of the investigation.

The Department agrees. In June 2022, to ensure that children brought to the attention of the Department are seen and contact is documented timely in SACWIS, the Department, in collaboration with the Department of

Innovation and Technology (DOIT) created an interactive dashboard using analytics software (PowerBI). The dashboard is updated daily and provides data to the field at the statewide, regional, sub-regional, team and individual worker levels.

3. The OIG reiterates the previous recommendation from 2021 IG 0069, that the Department should increase the number of Emergency Services workers available for after-hours and on weekends to ensure that children are being seen in a timely manner.

The Department agrees. The issue has been addressed with the implementation of the interactive dashboard. In addition, weekend blitzes are utilized to address child victims that have not been seen and child protection supervisors have the ability to utilize additional staff after hours as needed.

4. The OIG reiterates the previous recommendation from 2013 IG 1109, that if child protection investigators cannot meet their obligation to assess child(ren) in a timely manner the supervisor should assure that the police are contacted for a welfare check.

The Department agrees. In June 2022, to ensure that children brought to the attention of the Department are seen and contact is documented timely in SACWIS, the Department, in collaboration with the Department of Innovation and Technology (DOIT) created an interactive dashboard using analytics software (PowerBI). The dashboard is updated daily and provides data to the field at the statewide, regional, sub-regional, team and individual worker levels.

PART II: CHILD DEATH REPORT

Pursuant to Illinois Register at 89 Ill. Admin. Code 430, the Inspector General investigates deaths or serious injuries in foster homes, child welfare institutions, independent living programs and other facilities licensed by the Department, as well as deaths or serious injuries when there was an open child welfare service case or child protection investigation by the Department within the preceding 12 months. The death of a child is always tragic. For that reason, the OIG uses deaths as a milestone to review the Department's involvement with that family. The OIG review is based upon the work even beyond the contributory path to the death. Problems not truly connected to the death could come to light. A death is not always a reflection of errors on the part of Department or private agency workers.

OIG staff receive notification of the death of a child mainly from the Illinois State Central Register (SCR). This year the OIG learned, from the Child Death Review Team, of additional deaths that had not been reported to SCR. OIG staff investigate the Department's prior involvement with the deceased and their family when (1) the child was a youth in the care of DCFS within a year of their death; (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.

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 death certificate and autopsy reports when available. Records may be requested, impounded, or subpoenaed. The majority of cases involve an investigatory review of DCFS and private agency case records.

Those reviews which identify malfeasance or misfeasance of Department and private agency employees, as well as systemic problems and errors, may move to a full investigation. The issues identified may or may not relate to the death itself. As part of a full investigation, additional records – often including social service, medical, police, and school records – may be requested and interviews conducted. A full investigation may result in a report to the Director of DCFS.

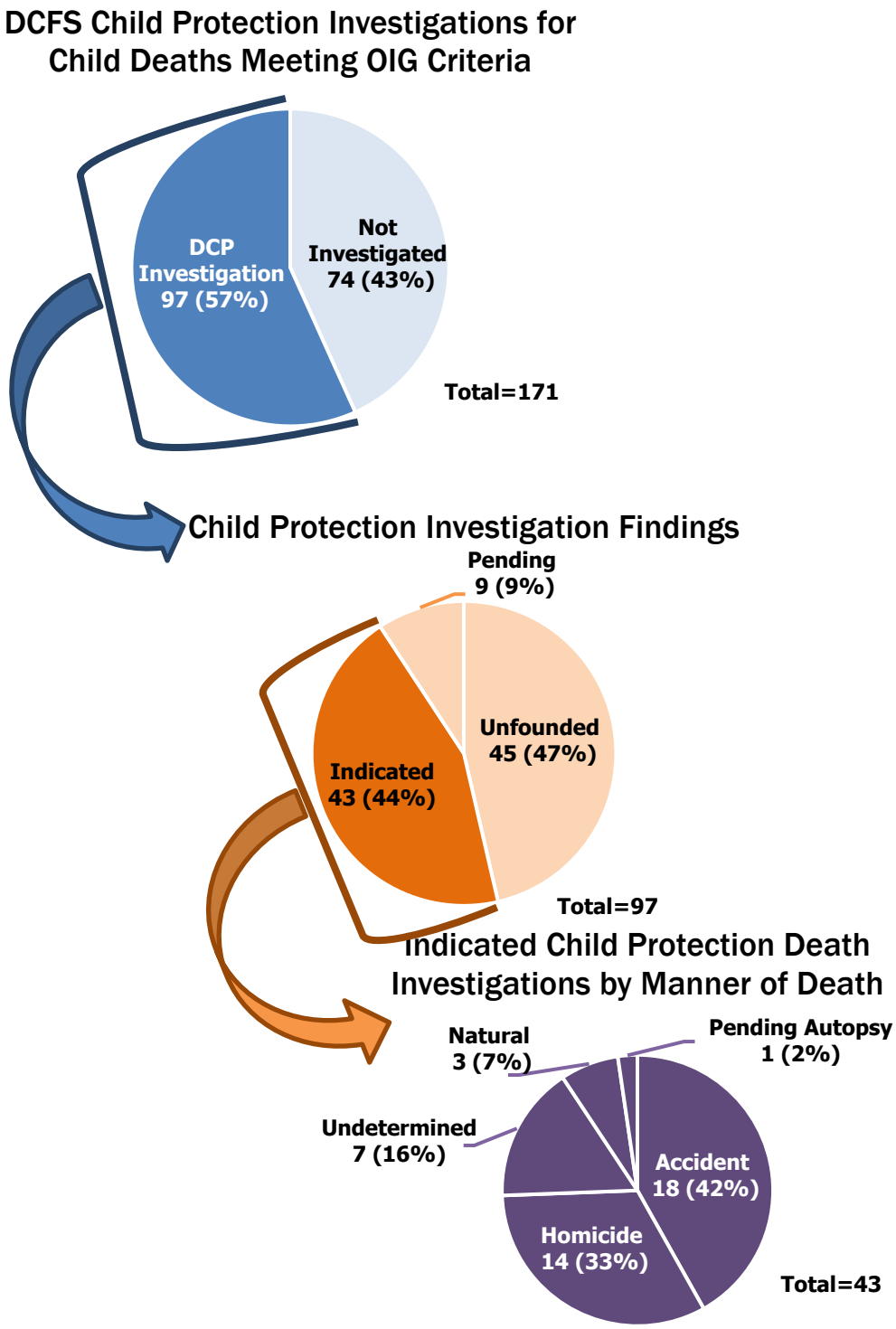
When issues identified in multiple cases indicate systemic patterns the OIG makes recommendations to the Director to address systemic issues through a variety of means. These include systemic issue reports, initiatives, and trainings. OIG investigations from this fiscal year are being incorporated into Error Reduction Training plans to be presented to the Director in 2023. This year OIG investigators found several child protection investigations in which the alleged child victims were not seen in accordance with procedures 300 and therefore, were not assessing the safety of alleged child victims.

In Fiscal Year 2022, OIG investigators completed an investigatory review of 171 deaths of children who died between July 1, 2021, and June 30, 2022. A description of each child's death and DCFS involvement is included in this Annual Report. OIG investigators determined 37 deaths required full investigations. One systemic report included 13 deaths addressing a systemic concern. Comprehensive summaries of death investigations reported to the Director in FY 2022, which may include deaths that occurred in earlier fiscal years, are included in Part I: Death and Serious Injuries Investigations.

Of the 171 child deaths reviewed by OIG, the Department conducted a child protection investigation for allegations of death by abuse or neglect in 97 (57%) of the deaths. Of those 97 deaths, the Department indicated a perpetrator for death by abuse or neglect in 43 deaths (44%) and unfounded an alleged perpetrator for death by abuse or neglect in 44 (45%) deaths; 10 child protection death investigations (10%) remain pending at the time of this report. Of the 97 deaths investigated by the Department for death by abuse or neglect, 18 of the deaths were ruled homicide in manner, 17 had an undetermined manner, 30 had

a manner of accident, and 28 had a manner of natural. Autopsy results have not been released for four of these deaths.

OIG FY 2022 DEATHS WITH CHILD PROTECTION INVESTIGATIONS INTO THE DEATH



STATISTICAL SUMMARY

The following is a statistical summary of the 171 child deaths reviewed by OIG in FY 2022. 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. This year there are five deaths for which autopsy results have not yet been released and thus this report has a list of deaths classified under a pending classification section. 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 (see Table 2)

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 Intact	Family had an open intact family services case at time of child's death.
Closed Intact	Family had an intact family services case 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/Closed Placement	Deceased or sibling(s) returned home to parent(s) from foster care within a year of child's death, or siblings of deceased adopted 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 their death.

TABLE 1: CHILD DEATHS BY AGE AND MANNER OF DEATH								
	CHILD AGE	HOMICIDE	SUICIDE	UNDETERMINED	PENDING	ACCIDENT	NATURAL	TOTAL
Months of Age	At birth	1					2	**3**
	0 to 3			7	1	9	16	**33**
	4 to 6	2		5		6	4	**17**
	7 to 11	1			2	2	4	**9**
	12 to 24	4		3		4	8	**19**
Years of Age	2	3				3	3	**9**
	3			1	1	2	4	**8**
	4	1		1		1		**3**
	5	1					1	**2**
	6	3				2	2	**7**
	7	1					1	**2**
	8	2					2	**4**
	9						5	**5**
	10						1	**1**
	11		1				1	**2**
	12	1	1			1	3	**6**
	13	1		1			2	**4**
	14	3				2	1	**6**
	15	1	1		1			**3**
	16	3	1			1	2	**7**
	17	5	1			4	4	**14**
	18 or older	3	1	1		1	1	**7**
TOTAL		**36**	**6**	**19**	**5**	**38**	**67**	**171**

TABLE 2: CHILD DEATHS BY CASE STATUS AND MANNER OF DEATH								
REASON FOR OIG INVESTIGATION*		HOMICIDE	SUICIDE	UNDETERMINED	PENDING	ACCIDENT	NATURAL	TOTAL
DCP	Pending	6	1	5	2	9	11	**34**
	Unfounded	11	3	4	1	11	23	**53**
	Indicated	4		1		2	4	**11**
Youth in Care		9	1	3	1	3	9	**26**
Former Youth in Care				1			3	**4**
Return Home/ Closed Placement		1				1	1	**3**
Open Placement/ Split Custody		1				3	2	**6**
Open Intact		4		3		5	11	**23**
Closed Intact			1	1	1	3	2	**8**
Child of a Youth in Care						1		**1**
Child Welfare Services Referral				1			1	**2**
Preventive Services/ Extended Family								**-**
TOTAL		**36**	**6**	**19**	**5**	**38**	**67**	**171**

* *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**	**PENDING**	**ACCIDENT**	**NATURAL**	**TOTAL**
Calhoun					1		**1**
Champaign	1	2				3	**6**
Christian						1	**1**
Clark						1	**1**
Coles					1	1	**2**
Cook	20		7	3	10	21	**61**
Cumberland						1	**1**
De Witt						1	**1**
Dekalb	1						**1**
DuPage	1				1	1	**3**
Edgar						1	**1**
Fayette						1	**1**
Franklin					2	2	**4**
Fulton						1	**1**
Jackson				1			**1**
Jefferson			1		1		**2**
Kane	2					1	**3**
Kankakee						1	**1**
Knox						1	**1**
La Salle						1	**1**
Lake	2	2			1		**5**
Lawrence					1		**1**
Lee			1				**1**
Macon	1					1	**2**
Madison				1	1	3	**5**
Marion						1	**1**
Massac			1				**1**
McDonough						1	**1**
McHenry					1		**1**
McLean	1		1				**2**
Montgomery						1	**1**
Ogle					1		**1**
Peoria	4		2		1	4	**11**
Perry			1				**1**
Piatt						1	**1**
Pulaski						1	**1**
Randolph					1		**1**
Rock Island					3		**3**
Sangamon	1				3	2	**6**
Shelby						1	**1**
St. Clair	1				2	6	**9**
Tazewell		1			1		**2**
Whiteside			1			1	**2**
Will			2		2		**4**
Williamson					1	1	**2**
Winnebago	1	1	2		3	4	**11**
TOTAL	**36**	**6**	**19**	**5**	**38**	**67**	**171**

TABLE 4: CHILD PROTECTION DEATH INVESTIGATIONS BY RESULT AND MANNER*							
FINAL FINDING	**HOMICIDE**	**SUICIDE**	**UNDETERMINED**	**PENDING**	**ACCIDENT**	**NATURAL**	**TOTAL**
Indicated	14		7	1	18	3	**43**
Unfounded	1		10		10	23	**44**
Pending	3			3	2	2	**10**
TOTAL	**18**	**0**	**17**	**4**	**30**	**28**	**97**

**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 2022 DEATH CLASSIFICATION BY MANNER OF DEATH

HOMICIDE

Thirty-six deaths were classified as homicide in the manner of death.

CAUSE OF DEATH	NUMBER
Blunt force injuries	1
Drug toxicity	1
Gunshot wound(s)	19
Multiple injuries due to child abuse and/or neglect	13
Stab wound(s)	1
Suffocation	1
TOTAL	**36**

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ALLEGED PERPETRATOR INFORMATION*

PERPETRATOR	NUMBER
Mother	6
Father	7
Mother's paramour	4
Father's paramour	1
Sibling	2
Deceased's boyfriend	2
Unrelated person(s)	8
Unknown	10

**Some deaths have more than one perpetrator*

SUICIDE

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

CAUSE OF DEATH	NUMBER
Drug toxicity	1
Gunshot wound(s)	2
Hanging	3
TOTAL	**6**

UNDETERMINED

Nineteen deaths were classified undetermined in the manner of death.

CAUSE OF DEATH	NUMBER
Drowning	1
Gastrointestinal obstruction	1
Gunshot wound(s)	2
Possible hypothermia	1
SUID* or undetermined - sleep related	5
Undetermined	9
TOTAL	**19**

** Sudden unexpected infant death*

ACCIDENT

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

CAUSE OF DEATH	NUMBER
Blunt force injuries	1
Drowning	7
Drug toxicity	3
House fire	1
Motor vehicle accident related	13
Sleep related	13
TOTAL	**38**

Sixty-seven deaths were classified natural in the manner of death.

CAUSE OF DEATH	NUMBER
Cancer	3
Cardiac condition	4
Chronic gastrointestinal illness	1
Complications of anoxic injury	2
Complications of congenital anomalies	8
Complications of diabetes	1
Complications of genetic disorder	3
Complications of immune disorder	1
Complications of kidney disease	1
Complications of liver disease	1
Complications of neurological condition (seizure disorder, cerebral palsy, or other)	10
Complications of organ transplant	1
Pneumonia, sepsis, viral infection, or bacterial infection	21
Prematurity	7
SUID*	2
Undetermined	1
TOTAL	**67**

**Sudden unexpected infant death*

HOMICIDE

Child No. 1	DOB: 12/2006	DOD: 07/2021	Homicide
Age at death:	14 years		
Cause of death:	Multiple blunt and sharp force injuries of head due to assaulted by other person(s)		
Alleged perpetrator:	Unrelated person		
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 found lying face up, unresponsive, by law enforcement responding to a possible hit-and-run. He was pronounced deceased at the scene. The day before, the teen's father had filed a missing person report after he did not return home from mowing a lawn and did not respond to phone calls. An unrelated person has been charged with his murder and is awaiting trial. DCFS did not investigate the teen's death.

Reason for Review: The teen and his siblings had previously been removed from and returned to their father's care. In April 2021, DCFS opened an investigation following a report that the father had been drinking, smoking marijuana, and driving while intoxicated with children in the car. The reporter also stated the teen had mental health issues, was using drugs, and was stealing, and the father failed to address these problems. The teen admitted to stealing marijuana from his sister a few weeks prior but denied using other drugs. The father reported using marijuana but denied current use of alcohol or other drugs; he reported a history of drug use and treatment. He denied providing any drugs to the teen. The teen, his then 6-year-old sister, and his then 5-year-old brother all denied physical punishment and appeared clean and healthy. The children's childcare provider, the father's recovery group sponsor, and staff from their primary care provider's office all denied concerns regarding the father's parenting. In June 2021, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 2	DOB: 06/2020	DOD: 07/2021	Homicide
Age at death:	13 months		
Cause of death:	Asphyxia due to wedging between a bed and wall; significant contributing conditions of melatonin ingestion and general neglect by caregiver(s)		
Alleged perpetrator:	Child's mother		
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 his mother between the wall and a twin bed he shared with his sibling. The toddler was transported by ambulance to the hospital, where he was pronounced deceased. His mother reported she found him unresponsive at 10:00am but paramedics were not dispatched until 11:38am. She reported she left the children with a babysitter around 11:00pm the previous evening, but the babysitter lived in the apartment next door, and she knew the babysitter was not staying in the home. The mother reported she checked on the children around 11:45pm. The babysitter reported checking on the children around 12:30am and stated she believed the mother returned around 2:00am. DCFS indicated the mother for death by neglect. A criminal investigation was also conducted but the mother was not arrested.

Reason for Review: In June 2021, DCFS received a report that the home was dirty, the mother did not change the toddler's diapers, and the mother often left a 10-year-old child to watch the toddler, his 22-month-old, 3-year-old, and 5-year-old siblings when she left the home. The child protection investigator (CPI) met with the family at home the following day and observed no environmental hazards and the children appeared healthy, clean, and appropriately dressed. The mother reported she never left

her children unsupervised and the maternal aunt, who was at the home at the time of the interview, often watched the children. The mother declined services. Four days before the toddler's death, DCFS unfounded the investigation for environmental neglect and inadequate supervision.

Child No. 3	**DOB: 10/2007**	**DOD: 09/2021**	**Homicide**
Age at death:	13 years		
Cause of death:	Gunshot wound of the back		
Alleged perpetrator:	Child's brother		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old was shot by his 17-year-old brother. The mother stated she heard the boys arguing in their room while playing video games; she heard the shouting escalate, and the brother told her he shot the teen. The brother called 911, and the mother began CPR. The teen was pronounced deceased at the hospital. The mother stated she did not know the gun was in the home. Police arrested the brother for unlawful use of a weapon. The brother stated he and his brother were eating at the time and were not fighting. He stated he did not know the gun was loaded. He stated he was not under the influence of any drugs at the time of the incident. The mother later stated she did not hear arguing prior to the shooting. The State's Attorney determined the shooting was accidental. DCFS investigated the teen's death and indicated the teen's brother for death by abuse.

Reason for Review: In April 2021, DCFS received a report that the teen's then 16-year-old brother disclosed he had been sexually abused by their cousin four years earlier while the cousin lived in the home. The brother later disclosed he had molested the teen. The brother was receiving inpatient psychiatric treatment at the time of the report, and the parents stated they planned for the teen to stay with relatives when the brother was discharged from the hospital. The parents also stated the cousin had moved out of the home and did not have access to the teen or his brother. During a forensic interview, the brother denied his earlier disclosures and stated he had been intoxicated when he reported the abuse. The teen and other family members denied any sexual abuse. That same day, the mother disclosed a history of domestic violence in the home, and DCFS added allegations to the investigation. In July 2021, DCFS unfounded the allegations of sexual molestation by abuse and substantial risk of sexual abuse. DCFS also unfounded the allegation of substantial risk of physical injury/environment injurious to health and welfare by abuse because neither the teen nor brother had any signs of abuse, and the parents and brother reported only one domestic violence incident.

Child No. 4	**DOB: 03/2004**	**DOD: 09/2021**	**Homicide**
Age at death:	17 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown		
Reason for review:	Open intact family services case at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was walking on the sidewalk of the street where he lived when a vehicle pulled up behind him, two unidentified individuals got out, ran after the teen, and fired multiple shots at him. The teen was transported to the hospital by ambulance and underwent surgery, but he died at the hospital. DCFS did not investigate the teen's death.

Reason for Review: At the time of his death, the teen lived with his mother, four adult siblings, and three nephews, who were children of his 21-year-old sister and were between the ages of 1 to 3 years. In August 2020, DCFS received a report that the teen's sister was not feeding her then 10-month-old and 1-year-old children, the children often begged for food, and they appeared underweight. The reporter also

stated screaming and crying could be heard from the home, which was often unsanitary. The next day, the CPI observed unsafe conditions in the home, including mice droppings on kitchen surfaces, flies around open garbage in the kitchen, and holes in the walls. The children did not have any injuries. The sister stated her children ate regularly, and denied excessive noise, screaming, and crying. She stated they clean daily, including mopping and sweeping, and their landlord would exterminate the mice. The sister stated she was pregnant. The teen, his mother, and his brothers also denied the allegations in the report and stated they had no concerns about the children's care. The children were temporarily placed with their father under a safety plan due to the home conditions. One week later, the CPI observed the home to be in better condition, but an exterminator had not yet come to the home and the holes in the walls had not been fixed. The property manager stated the apartments are typically exterminated once per month or as needed, but the family's home was always dirty and had food all over. The family hired an exterminator who treated the home that weekend. Later that month, the sister gave birth to a third son. The sister had safe sleeping arrangements for her children. In October 2020, DCFS indicated the teen's sister for environmental neglect to her children. DCFS opened an intact family services case for the sister. The intact worker met with the teen several times and observed him to be free of visible signs of abuse or neglect. At the time of his death, the teen was not in school because he had been expelled from multiple schools because of poor attendance. The sister's intact case has since closed successfully.

Child No. 5	**DOB: 03/2004**	**DOD: 09/2021**	**Homicide**
Age at death:	17 years		
Cause of death:	Gunshot wound of the head		
Alleged perpetrator:	Unrelated persons		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old and a male peer were found early in the morning in a parked vehicle with gunshot wounds to their heads. They were airlifted to hospitals for treatment. The teen died at the hospital later that morning. Two adults and a 16-year-old were arrested on charges of first-degree murder, and an arrest warrant was issued for another suspect. DCFS did not investigate the teen's death.

Reason for Review: In August 2020, DCFS received a report that the teen disclosed physical abuse by her relative adoptive mother, had bruises all over her body, had been sexually assaulted by her adoptive cousin, and had run away from home. The teen's adoptive mother also reported the teen was on run. The CPI located the teen at her biological mother's home and did not observe any marks or bruises on the teen. The teen denied being abused, but she did not want to return to her adoptive home. The CPI called in a crisis worker to arrange for a shelter placement for the teen. The teen eventually returned to her adoptive home, and the CPI made a referral to a DHS-funded program to work with the family. In September 2020, the investigation was unfounded. In November 2020, DCFS received another report that the teen ran away to her biological mother's home and would not return. Police stated they could not assist. The adoptive mother stated she saw a video of the teen fighting a peer at school on social media and alleged the teen's biological mother contacted the peer's mother to facilitate the fight. The teen denied the fight was planned, and the teen's biological mother and grandmother denied involvement in the fight. The teen stated she was no longer speaking to her adoptive mother and had recently been staying at her biological grandmother's home. In February 2021, DCFS unfounded the investigation. The adoption unit and the family's youth advocate were notified of the adoption disruption. The adoption unit advised the teen's biological grandmother should be provided with information on obtaining guardianship.

Child No. 6	DOB: 05/2021	DOD: 10/2021	Homicide
Age at death:	4 months		
Cause of death:	Multiple injuries due to child abuse		
Alleged perpetrator:	Child's father		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Four-month-old was brought to the hospital by her father after she was found unresponsive by a family friend. She was not breathing upon arrival and was pronounced deceased at the hospital. The infant's body had multiple injuries, including skull and rib fractures; soft tissue hemorrhages and healing abrasions to her head, neck, torso, and all extremities; extensive injuries to her central nervous system and eyes; and a hepatic hematoma. The infant was in the care of her father at the time of her death, and medical staff stated the infant died four to six hours before she was brought for medical care. DCFS investigated and unfounded the family friend. DCFS indicated the father for death by abuse. Law enforcement has a criminal case pending against the father.

Reason for Review: In February 2021, DCFS received a report that the father's then paramour brought her 4-year-old child to the hospital for a rash and hair loss; hospital staff observed bruises on the child's back, chest, neck, and ear; the paramour could not explain the injuries; and the child's toxicology report was positive for THC, nicotine, and caffeine. The hospital took protective custody of the child. DCFS placed him initially with a mentor of the paramour, then with his father. The paramour denied smoking around or injuring her son, and stated she believed the marks on his body were caused by a skin condition. The child stated the infant's father caused the marks on his body, and his mother did not hurt him. Medical providers treating the child stated they did not believe the marks were caused by his rash. The State's Attorney declined to accept the case. The paramour agreed to participate in voluntary intact family services. The CPI attempted to interview the infant's father, who stated he no longer lived in the state, but he made an appointment to meet with the CPI when he would be in the area again. He failed to attend the appointment or to return messages. In June 2021, DCFS indicated the infant's father for cuts, bruises, welts, abrasions, and oral injuries by abuse and neglect and substance misuse by neglect. DCFS unfounded the father's paramour. The father was not involved in the paramour's intact family services case.

Child No. 7	DOB: 03/2019	DOD: 10/2021	Homicide
Age at death:	2 years		
Cause of death:	Multiple injuries due to child abuse		
Alleged perpetrator:	Child's mother and mother's paramour		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old was brought to the hospital by her mother with multiple head traumas, abrasions, scabs, scars, strangulation marks around her neck, and thermal injuries to her hands. The mother told hospital staff that she found the toddler unresponsive in her bed. She left the toddler with her paramour the previous day and reported that the toddler tried to grab the hot stove, then fell and hit her head. The injuries were at different stages of healing and consistent with child abuse. The mother and her paramour were arrested and charged with homicide. A criminal case remains pending. DCFS indicated the mother and paramour for death by abuse. DCFS also indicated the mother for head injuries by abuse; wounds by abuse; and cuts, bruises, welts, abrasions, and oral injuries by abuse.

Reason for Review: In August 2021, DCFS received a report that the mother's paramour beat the toddler with a belt on her back while the mother stood by; the toddler was often made to kneel down and carry heavy objects, and had weight added to the load or was hit with a belt if she dropped the objects; and the home had a mold infestation, inadequate utilities, and was in poor condition. The CPI made multiple unsuccessful attempts to locate and contact the family. During one attempt, a man at the address

identified himself as a new tenant and reported he did not know the family who had moved out. The investigation remained pending at the time of the child's death. After the death, DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect, and unfounded the investigation for inadequate shelter and environmental neglect.

Child No. 8	**DOB: 07/2004**	**DOD: 10/2021**	**Homicide**
Age at death:	17 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Seventeen-year-old was shot 14 times in the street. He was brought to the hospital in full arrest and pronounced deceased. Police have not identified a suspect. DCFS did not investigate his death for abuse or neglect.

Reason for Review: In November 2020, DCFS received a report that the family home had no electricity or heat, and there were unsecured guns on the table within reach of children. The CPI made a good faith attempt to see the children at home that day, sent a letter to the home, and made a second good faith attempt approximately three weeks after the investigation opened. In late December, the CPI learned the teen was detained in a juvenile detention facility and met with the family at their home. The home was observed to have electricity, heat, and food. The teen's nephews, who were present but did not live in the home, reported they had never seen guns in the home or in their grandfather's home. Collateral contacts also reported they had never seen guns in the home. The CPI spoke with the teen and teen's juvenile delinquency case manager, who reported he was being detained for a weapons charge. In January 2021, DCFS unfounded the investigation for inadequate food and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 9	**DOB: 02/2004**	**DOD: 10/2021**	**Homicide**
Age at death:	17 years		
Cause of death:	Gunshot wound to abdomen		
Alleged perpetrator:	Teen's boyfriend		
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 pronounced deceased at the hospital with a single gunshot wound to the stomach. A reporter stated the teen's boyfriend came to the home, made threats, and attempted to get into the home, but the teen closed the door to prevent him from coming in. The boyfriend shot a single bullet through the door, which hit the teen and killed her. The teen's aunt stated she was aware of the relationship but did not condone it, and the teen would often sneak out to meet up with her boyfriend. DCFS did not investigate the teen's death for abuse or neglect. The police did not arrest the boyfriend and no charges were filed.

Reason for Review: The teen lived with her aunt since the age of 3 years. In January 2021, police arrested the teen's 26-year-old boyfriend for domestic battery after responding to a domestic violence call at a hotel. DCFS opened an investigation into the teen's boyfriend. The teen's aunt stated the teen often did not listen and did what she wanted. The aunt stated she knew the teen was in a relationship but had not met the teen's boyfriend. The boyfriend stated the teen told him she was 18 years old, and the teen admitted to lying about her age. DCFS unfounded the investigation due to insufficient evidence because the teen's boyfriend was not an eligible perpetrator, as he was not in a caretaker role.

Child No. 10	DOB: 10/2007	DOD: 11/2021	Homicide
Age at death:	14 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown		
Reason for review:	Open intact family services case and pending child protection investigation; and indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old was shot and killed while standing on a sidewalk a block from his home. The teen's mother reported the teen was on his way home from the store and stated she believed it was a case of mistaken identity. She denied the teen was involved in a gang. DCFS did not investigate the teen's death.

Reason for Review: The teen had five siblings, between the ages of 4 and 15 years. In December 2020, DCFS opened an intact family services case after the parents were indicated for environmental neglect and the mother was indicated for inadequate food. At the transitional visit for the intact case, the home was noted to require repairs but was considered safe. Recommended services included parenting education, counseling, and a developmental assessment for the youngest child. The mother reported struggling since the death of her mother, who had been a significant source of support for the family and had died after the teen's maternal uncle was shot and killed. During another visit that month, the intact worker observed ample food in the home, the children did not show signs of abuse or neglect, and the father reported he continued to work on home repairs. In January 2021, the mother reported there was an electrical fire on the back porch and the home was damaged, but no one was injured. The intact worker shared information on housing services but the mother reported it would be more cost effective to make repairs to the home. In February 2021, the father began parenting classes. In March 2021, the mother began therapy. That month, DCFS opened an investigation after the intact worker observed a red mark on the cheek of the teen's then 10-year-old sister and hand of the 9-year-old sister. The mother admitted she used a phone charger cord to hit the sisters on their hands for failing to clean their room, and the cord accidentally hit the 10-year-old in the face. The CPI met with the father in the home, who reported he was in another part of the home when the incident happened. The CPI directed the parents to take the 10-year-old for a medical exam. In May 2021, the CPI returned to the family home and observed the 4-year-old brother had a scratch and bruise on his forehead. The mother explained that he fell off the porch, while he was unsupervised. The CPI directed the parents to take the brother for a medical exam, and the treating physician reported no concerns. DCFS indicated the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse; inadequate supervision; and substantial risk of physical injury/ environment injurious to health and welfare by neglect. The mother agreed to continue to cooperate with intact services. In June 2021, the mother completed parenting classes successfully and she was making progress in therapy, but it was reported she may benefit from a psychiatric evaluation. The father was incarcerated for outstanding gun charges. During the summer, the 9-year-old and 10-year-old sisters went to stay with relatives out of state and the teen attended summer school regularly. In August 2021, the sisters stated they wished to stay with the relatives, who agreed to continue caring for them. The intact worker completed short-term guardianship paperwork for the sisters. In September 2021, the father was released from jail on house arrest and reported he no longer wished to participate in DCFS services. The parents reported they were no longer romantically involved but the father would continue to remain in the home until he completed his house arrest. In November 2021, the father moved out of the home and the mother reported the teen's 4-year-old brother went to live with a relative who also had guardianship of the teen's 15-year-old sister. The morning of the teen's death, DCFS received a report that the mother had abandoned the home leaving the teen alone for multiple weeks. The reporter also alleged the teen was selling drugs, the teen's younger siblings were missing, and the home had been shot at multiple times. A CPI met with the mother and teen at the home that day and observed multiple safety hazards, including broken windows, garbage and clutter throughout the home, and mold and water damage to the walls and ceiling. The mother denied leaving the children home alone, reported the teen's siblings were living with

relatives, and denied the home had been shot at but acknowledged that there had been shootings in the neighborhood. The teen refused to speak with the CPI. The teen was shot and killed that evening. Two days later, the mother was shot and killed on her way to light a candle where the teen had been shot. DCFS later unfounded the investigation for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. The intact case remained open, and the intact worker provided information on obtaining guardianship to the relatives who were caring for the teen's siblings.

Child No. 11	**DOB: 09/2003**	**DOD: 11/2021**	**Homicide**
Age at death:	18 years		
Cause of death:	Gunshot wound of the chest		
Alleged perpetrator:	Unknown		
Reason for review:	Deceased was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Eighteen-year-old was shot five times by an unknown assailant while sitting in a car with his girlfriend. The teen was taken to the hospital, where he died. DCFS did not investigate the teen's death.

Reason for Review: At the age of 11, the teen's great-grandmother was awarded subsidized guardianship. In 2017, juvenile delinquency court ordered the teen into DCFS custody because of his behavioral issues and criminal activity. The teen was released from juvenile detention to a court ordered institutional placement for behavioral problems. He was released back to his grandmother's home for a few months in 2018, before being detained by law enforcement and again placed in juvenile detention. He was court ordered to inpatient substance use disorder treatment in 2019. After being discharged from inpatient treatment, he returned to his grandmother's home. In 2021, he was arrested and charged with aggravated discharge of a firearm and unlawful use of a weapon. He was adjudicated and placed in detention. In September 2021, the teen was released from detention with an electronic ankle monitor to the home of his father. The teen's DCFS placement worker attempted to visit the teen at his father's home multiple times without success prior to his death.

Child No. 12	**DOB: 03/2016**	**DOD: 12/2021**	**Homicide**
Child No. 13	**DOB: 12/2014**	**DOD: 12/2021**	**Homicide**
Age at death:	5 years; 7 years		
Cause of death:	Gunshot wound of the head; gunshot wounds of the head and back		
Alleged perpetrator:	Unrelated person		
Reason for review:	Unfounded child protection investigation and siblings returned home within one year of children's deaths		
Action taken:	Investigatory review of records		

Narrative: Five-year-old, seven-year-old, and their father were found in their father's home, with gunshot wounds to the back of their heads. The boys were visiting their father. Police arrested a man for all three murders, who stated he worked for the father selling marijuana and owed the father a large sum of money. DCFS did not investigate the children's deaths.

Reason for Review: The boys' maternal grandparents had been their legal guardians for the five years preceding their death. In March 2020, DCFS took protective custody of the boys' then 1-year-old sister. In April 2020, DCFS also took protective custody of their infant brother following his birth. Both parents engaged with services through their placement case. In September 2020, the mother began unsupervised visits and in November 2020, the father began unsupervised visits. In November 2020, the court returned the infant brother and 1-year-old sister to their mother's care and ordered six months of aftercare services; six months later, in May 2021, the court returned custody of the infant and 1-year-old to their parents. In March 2021, DCFS received a report that the mother witnessed the maternal grandparents' dog bite the

5-year-old close to the eye while on a video call and she had seen the dog bite the 7-year-old in the past. The maternal grandparents and the boys told the CPI that the dog did bite the 5-year-old, but he had cornered the dog, and his grandparents had told him not to do so several times. The grandparents took the 5-year-old for medical attention, and the treating physician stated his injury was consistent with the report. The 5-year-old did not report any abuse or concerns with his grandparents. In April 2021, DCFS unfounded the investigation.

Child No. 14	**DOB: 04/2021**	**DOD: 12/2021**	**Homicide**
Age at death:	7 months		
Cause of death:	Cranio-cerebral injuries due to blunt force trauma		
Alleged perpetrator:	Unknown		
Reason for review:	Open intact family services case at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-month-old found unresponsive on a sofa by his paternal aunt, who called 911. The infant was transported to the hospital by ambulance, where he was pronounced deceased. An autopsy revealed multiple brain bleeds and skull fractures. A DCFS investigation and criminal investigation into the infant's death remain pending.

Reason for Review: In October 2020, DCFS opened an intact family services case following an unfounded child protection investigation. Initial services included a mental health assessment for the mother and parenting classes for both parents. The intact worker observed a pack-and-play for the infant's then 7-month-old brother that was being used as storage and instructed the parents to clean it so it could be used for sleeping. At the time, the mother was pregnant with the infant and was encouraged to obtain prenatal care. The intact worker continued to make regular visits. In November 2020, DCFS received a report that law enforcement responded to a domestic disturbance at the home, in which the mother threatened to harm herself and the then 9-month-old brother. Responding officers reported the incident was a verbal altercation and they petitioned to have the mother involuntarily admitted for a psychiatric evaluation. The mother was hospitalized and later discharged to a family member. The father stated the mother threatened him and the brother when he returned home from buying diapers. The mother denied the allegations. After the incident, the father brought the brother to the home of the paternal grandmother, who had an order of protection against the mother due to prior incidents. The father agreed not to allow the mother around the brother until she received further assessment. The CPI provided a pack-and-play and the brother was assessed safe with his father in the paternal grandmother's home. Two weeks after the Hotline report, the paternal grandmother reported the father left several days earlier and she did not know where he went. She continued to care for the brother. The CPI screened the case with the State's Attorney, who declined to accept the case. In December 2020, the mother was not participating in services. The mother reported that she was compliant with her psychotropic medication. The father reported he had been staying with a friend since he left the paternal grandmother's home. Both parents agreed to comply with services and to keep the brother in the care of his paternal grandmother until they began services. In January 2021, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect. In February 2021, the family's intact worker reported the parents had begun parenting classes, and the mother was receiving prenatal care and mental health services. In April 2021, the mother gave birth to the infant. The infant lived with his parents and his then 1-year-old brother continued to live with their paternal grandmother and visit with his parents. In August 2021, the parents successfully completed parenting services and the infant's pediatrician reported he was developing appropriately. In September 2021, the infant's brother began having extended visits with the parents. In October 2021, the parents began receiving services from a home visiting program to assist them in meeting the children's needs. Three weeks before the infant's death, the intact worker discussed closing the intact case with the parents. The following day, the father and the children left to stay with the paternal

grandmother after the father said he found the children home alone and the mother outside looking for him. He stated the mother became upset and told him to leave and threatened to harm herself. The intact worker called 911 for a wellness check and law enforcement reported no concerns. The intact worker visited the paternal grandmother's home, provided pack-and-plays for the children, and the father signed a safety plan that the children would not return to their mother's care. The intact worker provided the mother with a bus pass and instructed her to obtain a mental health assessment. Five days before the infant's death, the father reported he planned to keep the children with their paternal grandmother and did not plan to return to the mother's home.

Child No. 15	**DOB: 06/2009**	**DOD: 01/2022**	**Homicide**
Age at death:	12 years		
Cause of death:	Gunshot wound of the chest		
Alleged perpetrator:	Unrelated person		
Reason for review:	Two pending child protection investigations at time of child's death; three unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-year-old was found by his family after he was shot in the chest. The teen had been playing video games with his 13-year-old sister and a friend of the teen's 16-year-old brother, who had a handgun. The friend allegedly removed the magazine from the gun, pointed it at the teen, and pulled the trigger. Other family members heard the shot, found the teen unresponsive, and called 911. The teen was transported by ambulance to the hospital, where he was pronounced deceased. The family friend left the scene before police arrived and was later located and arrested; he has been charged with murder. The father did not live in the home and was not present at the time of the incident. The mother was asleep at the time of the incident and stated she did not know the friend was in the home. DCFS investigated the teen's death and unfounded his mother for death by neglect.

Reason for Review: In January 2021, DCFS received reports that the teen's then 21-year-old sister whipped her 4-year-old child with a cord, left him home alone for several hours, and used drugs. The reporter added that the child burned himself because his mother was not adequately supervising him. That day, the CPI met with the sister at home, who denied the allegations. She admitted to using alcohol and marijuana on occasion but denied other drug use. The child was observed to have a scar on one arm from being burned by water, but no other signs of injury. He denied his mother hit him with any objects and denied being afraid of her. Family members also denied the allegations and stated they believed the teen's 20-year-old brother called the Hotline because of family discord. During the investigation, the sister submitted a negative toxicology screening. In February 2021, while the investigation was pending, DCFS received a report that the sister was neglecting the nephew, but the Hotline worker noted the reporter was agitated, threatened to physically harm the sister, and used foul language. The Hotline worker contacted police for a child welfare check. In March 2021, while the first investigation remained pending, DCFS received a report that the teen's mother left the then 11-year-old teen and his then 9-year-old and 16-year-old brothers home alone without making a care plan, the teen had called the reporter and requested they be picked up because the mother was drunk and stated she would kill them, and there was domestic violence in the home. DCFS opened separate investigations against the teen's parents. The next day, the CPI met with the family and the children denied their parents fought. The parents each denied the allegations. Family members again stated they believed the teen's 20-year-old brother called the Hotline. Police reported there had been no service calls to the home for domestic violence. Later that month, DCFS unfounded the investigation against the sister for substantial risk of physical injury/environment injurious to health and welfare by abuse, burns by neglect, and inadequate supervision. DCFS also unfounded the investigations against the mother and the father for substantial risk of physical injury/environment injurious to health and welfare by neglect. In October 2021, DCFS received a report that the teen's 20-year-old brother had molested and penetrated the teen's 13-year-old sister, and the teen's mother knew

of the incident; the teen's 5-year-old nephew and 8-year-old brother had recently been left home alone; the teen's 20-year-old brother and 21-year-old sister had knocked over a pot of boiling water during an argument, which burned the teen's 8-year-old brother, and the brother did not receive medical treatment; and the mother and 20-year-old brother sold cocaine and the family used drugs in the home. DCFS opened an investigation against the mother and 20-year-old brother, and a separate investigation against the teen's 21-year-old sister. That day, the CPI made a good faith attempt to see the family. Two days later, the CPI spoke with the children through the window, but the mother was not home, and they declined to open the door. One week later, the CPI saw the teen's 5-year-old nephew, 8-year-old brother, and 12-year-old sister at school and noted the children had no visible bruises or burns. The children denied being abused and stated they felt safe at home. In December 2021, the teen's 12-year-old sister and 8-year-old brother completed forensic interviews. Neither child disclosed any abuse, and both stated they felt safe at home. Law enforcement interviewed the mother, who denied the allegations. The mother stated she believed the girlfriend of the 20-year-old brother called the Hotline because she was upset with him. The investigations remained pending at the time of the teen's death. DCFS later unfounded the investigation against the mother and 20-year-old brother for sexual penetration; substantial risk of sexual abuse; burns by neglect; inadequate supervision; environmental neglect; and substantial risk of physical injury/environment injurious to health and welfare by neglect. DCFS unfounded the investigation against the teen's sister for inadequate supervision.

Child No. 16	**DOB: 11/2020**	**DOD: 01/2022**	**Homicide**
Age at death:	13 months		
Cause of death:	Overdose of fentanyl		
Alleged perpetrator:	Child's father		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-month-old began choking while eating, and 911 was called. The father stated the toddler began making faces as if she were hurt, then closed her eyes and would not wake up. The toddler's paternal grandmother attempted CPR before paramedics arrived. The toddler was taken to the hospital by ambulance, where she was pronounced deceased. The toddler had been at her paternal grandparents' home overnight. Her mother had also spent the night, though she did not live in the home, and she left for work approximately three hours before the toddler's death. The father stated the toddler had a fever and the mother had given the toddler over-the-counter cough and cold medication before leaving for work. The treating physician at the hospital observed no blockages in the toddler's throat. An autopsy and toxicology screening revealed the toddler was positive for fentanyl. The father has been charged with endangering the life of a child causing death. DCFS investigated the toddler's death and indicated her father for death by neglect; her mother was removed as a subject of the investigation because she was not in the home at the time of the death.

Reason for Review: In December 2020, DCFS received a report that the toddler's umbilical cord tested positive for cocaine and hydromorphone upon her birth but had no signs of withdrawal. The mother had told the reporter she had been prescribed hydromorphone for pain a few days before the toddler's birth. The CPI documented the mother denied a history of drug use and stated the positive reading was because she had touched cocaine while spending time with associates that used drugs. The then 2-week-old was placed with her paternal grandmother under a safety plan. The mother agreed to complete toxicology screenings, participate in a substance use screening, adhere to all recommendations, and have supervised visits. The paternal grandmother agreed to the safety plan and denied knowledge that the mother used drugs. The mother completed substance abuse and mental health assessments, and no services were recommended. In January 2021, the mother had completed four urine toxicology screenings, all of which were negative, and the safety plan was terminated. Later that month, hospital staff confirmed the mother received hydromorphone at the hospital but had tested positive for cocaine two months before the birth

and tested positive for marijuana four months before the birth and stated she planned to cease using drugs. Hospital staff had no concerns for abuse or neglect and reported the mother was appropriate during appointments. DCFS indicated the mother for substance misuse by neglect.

Child No. 17	**DOB: 12/2015**	**DOD: 01/2022**	**Homicide**
Age at death:	6 years		
Cause of death:	Cardiopulmonary arrest due to hypothermia complicated with diphenhydramine poisoning		
Alleged perpetrator:	Child's mother and brothers		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Six-year-old's body was found in an alley in a neighboring state. Three days earlier, his mother reported him missing. The child had reportedly been in the care of his 16-year-old sister, who admitted to drinking alcohol and falling asleep while caring for the child. DCFS opened an investigation. When the child's body was found, it was reported he died one week earlier. The child's mother, 17-year-old brother, and 20-year-old brother have been arrested for criminal charges related to his death. DCFS indicated the child's mother for death by abuse and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: A case was opened in 2014 due to concerns of domestic violence, substance use, and mental health. Four children were in substitute care and three children were placed with their father. The mother successfully completed services, and the children were returned to her care in August 2017. In May 2021, DCFS received a report that the then 5-year-old child's mother sent text messages in which she threatened the child; called the child, his 6-year-old sister, and his 11-year-old brother derogatory names; stated she would not continue to raise them; the mother and had a history of substance use including during her last two pregnancies; and the then 5-year-old child was the size of a 3-year-old. The CPI made a good faith attempt to see the family that night. The following day, the CPI contacted the mother by phone, who refused to provide her current address. The mother eventually provided her address, which was in a different county than reported, and the CPI visited the family at home. The mother stated she had recently moved because she wanted a fresh start and denied the allegations. She reported she was on dialysis and denied using drugs or drinking heavily in recent years. She stated she lost custody of her children in 2014 and had worked hard to have them returned. The mother reported she believed the father of her youngest three children made allegations against her because she did not allow him to see the children. The CPI observed the child and five siblings, ages 4 to 17, and noted the children appeared well. The deceased child was observed to be small for his age. In June 2021, another CPI met with the mother and the child's teen and adult siblings and noted the siblings spoke well of their mother but were concerned about her health. Later that month, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect.

Child No. 18	**DOB: 09/2019**	**DOD: 02/2022**	**Homicide**
Age at death:	2 years		
Cause of death:	Blunt force trauma due to physical abuse		
Alleged perpetrator:	Child's father		
Reason for review:	Return home within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Two-year-old was found unresponsive, and 911 was called. First responders reported they found the toddler with bruises and injuries on multiple planes of her body. She was transported to the hospital, where she was pronounced deceased. The father stated the toddler had urinated on the couch, so he whipped her with a belt, washed her, noticed she was having trouble walking, and heard a thump when

she fell down. Both the father and paramour also reported he had whipped her the day before. The paramour stated that after she felt just spanking her wasn't working, she gave the father a belt to use. At autopsy, the pathologist found injuries on almost every area of her body consistent with child abuse. The toddler had been living with her father for approximately one month after the mother became homeless. The toddler's siblings were living with their respective fathers. The father has been charged with first degree murder and DCFS indicated the father for death by abuse; head injuries by abuse; internal injuries by abuse; and cuts, bruises, welts, abrasions, and oral injuries by abuse. DCFS investigated the mother and unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect because she made appropriate care plans with her children's fathers.

Reason for Review: The toddler and her three siblings came into DCFS care in 2020, after a shooting at their mother's home. In March 2021, the toddler's mother began receiving unsupervised visits with the then 17-month-old toddler and her then 2-year-old, 5-year-old, and 6-year-old siblings. In May 2021, the 5-year-old brother returned to the mother's care. In June 2021, the toddler and her 2-year-old and 6-year-old siblings returned home as well. The caseworker continued to visit the home over the next month. At her final visit, the caseworker documented the verbal children felt safe at home and the home was observed to be clean and free of visible safety concerns. In July 2021, the court ordered the children's placement case closed, and terminated DCFS' custody of the children. The father came into the toddler's life after the DCFS case was closed and was not involved with the mother during her DCFS case.

Child No. 19	**DOB: 03/2005**	**DOD: 02/2022**	**Homicide**
Age at death:	16 years		
Cause of death:	Stab wound of the back		
Alleged perpetrator:	Unrelated peer		
Reason for review:	Child was a youth in care; two pending child protections investigations at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old and his twin brother were involved in an altercation during which a peer stabbed the teen in the back. A peer has been criminally charged in connection with the death. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In November 2021, DCFS received a report that law enforcement had received multiple calls about the family and the teen's father kicked the teen and his twin brother out of the home due to their aggressive behavior. The father wanted them arrested because they kicked in the door after he locked them out of the home. The CPI met with the twins at the home, and they could not identify any family members to stay with. DCFS took protective custody of the twins. Their 13-year-old sister remained in their father's care. The court ordered the twins to be placed with their father under a supervision order. In December 2021, DCFS indicated the father for abandonment/desertion, inadequate supervision, and substantial risk of physical injury/environment injurious to health and welfare by abuse. Nine days later, DCFS received a report that the twins reported their father missing. DCFS opened an investigation but did not remove the twins from the home because they had just been placed there by a court order and they were old enough to stay home alone. While the previous investigation was pending, DCFS received a report that the father had left the home the previous day and had not returned. DCFS opened an additional investigation. In January 2022, the twins were removed from their father's home and placed with fictive kin. The father denied leaving the twins home alone, without food. When asked about the teen's 13-year-old sister, the father stated she was not part of the case, and she lived with relatives. The twins were enrolled in school and referred for individual therapy and anger management services. They reported they wanted to return to their father's home and missed their sister. In February 2022, the twins' foster mother informed their placement worker that while she was at work the previous night, unknown individuals went to her home and engaged in an altercation with the twins. The foster mother reported the

twin brother had been hit multiple times with a metal object but did not require medical care. The placement worker instructed her to seek medical attention for the teen. Four days later, the foster mother reported the teen had been stabbed. Both investigations remained pending at the time of the teen's death. DCFS later indicated the father on both investigations for inadequate supervision.

Child No. 20	**DOB: 07/2020**	**DOD: 02/2022**	**Homicide**
Age at death:	19 months		
Cause of death:	Blunt force injuries of the head		
Alleged perpetrator:	Paramour of child's father		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Full investigation; report to Director in FY 2023		

Narrative: Nineteen-month-old was found unresponsive and bleeding from the mouth while in the care of her father's paramour. The paramour called 911 and first responders reported the toddler was cold to the touch, did not have a pulse, and had significant bruising to her face and torso. The toddler was transported to the hospital by ambulance. Two days later, she was pronounced deceased. The paramour has been charged with murder as well as aggravated battery to a child related to the child protection investigation that was pending at the time of the toddler's death. The criminal case remains pending. The DCFS investigation into the toddler's death remains pending.

Reason for Review: In January 2022, DCFS received a report that after visiting her father's home, the toddler had bruises on her face and buttocks, abrasions on her lip, and a possible buckle fracture on her left arm. Hospital staff reported the mother told them the father's explanation of the injuries had changed multiple times. The toddler was discharged to the care of her mother. The next day, the CPI interviewed the mother at her home. The mother reported the toddler was visiting her father's home; the father's paramour, who was caring for the children while the father was at work, texted her that the toddler had been injured as she was standing behind the door with a sippy cup when the toddler's paternal half-brother and the paramour's nephew ran inside, and the door hit the toddler. The CPI advised the mother not to send the toddler to her father's home until DCFS could assess; the mother agreed. The CPI took photos of the toddler's injuries. Later that day, the CPI interviewed the toddler's 12-year-old paternal sister, who was not present for the incident, but reported she felt safe in the father's home. The 5- and 8-year-old half-siblings reported the toddler was standing by the door and got hit by the front door on the face while they and their friend were running in and out. They said their father was at work during the incident, and the paramour called the mother. The father reported he was at work when the incident happened but heard the same explanation. He stated he noticed the toddler had a bruise and was not using her arm as much as normal, and he shared that information with the mother. He stated the toddler had also fallen off a bed. He denied that he or his paramour used corporal punishment. The paramour reported that the boys knocked the toddler over, but she did not know if she was actually hit by the door, and she had been telling the boys to stop running in and out. She reported she contacted the mother and sent her photos as soon as the toddler calmed down, and she did not notice any issues with the toddler's arm until the following day. She denied they used corporal punishment. Approximately two weeks after the investigation opened, the CPI reported the mother contacted her and stated the father had been asking for the toddler to visit. The CPI advised the mother it was her decision as long as the mother believed the toddler would be safe. The investigation remained pending at the time of the toddler's death. DCFS later indicated the father and his paramour for cuts, bruises, welts, abrasions, and oral injuries by abuse.

Child No. 21	DOB: 09/2015	DOD: 02/2022	Homicide
Age at death:	6 years		
Cause of death:	Multiple injuries due to assault		
Alleged perpetrator:	Paramour of child's mother		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-year-old died at the hospital four days after being found unresponsive. The mother stated the child had abdominal pain and vomiting; he fell, hit his head, and became unresponsive. The child required intubation, and a CT scan revealed he had multiple brain bleeds. He was observed to have extensive bruising on his legs, buttocks, hips, and torso, as well as a small abrasion on his neck and various scars on his feet and legs. The 8- and 9-year-old sisters disclosed the paramour beat the child because he did not complete his homework. The mother was not home at the time. The paramour was arrested after he turned himself in and admitted to hitting the child and slamming his head into a wall. The mother reported the paramour had been abusive in the past. DCFS investigated the child's death and indicated his mother's paramour of death by abuse; head injuries by abuse; and cuts, bruises, welts, abrasions, and oral injuries by abuse; and substantial risk of physical injury/environment injurious to health and welfare by neglect. DCFS indicated his mother for death by neglect; head injuries by neglect; cuts, bruises, welts, abrasions, and oral injuries by neglect; and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In September 2021, DCFS received a report that the mother's paramour beat the child and his two siblings, and police had been to the home numerous times. The mother and her paramour denied any domestic violence to the CPI. The child and his siblings did not report any concerns. The mother stated she believed the maternal grandparents called the Hotline as retaliation because she no longer allowed them to watch the children. The children's father was incarcerated. In November 2021, the maternal grandfather stated he was concerned about the children and the mother; he believed the paramour beat the mother and sold drugs out of the home, the mother had blocked him from contacting the children, and he had called police to conduct wellbeing checks on the children. The CPI interviewed the children at school. The 8-year-old sister reported she got whipped on the bottom when she got in trouble, the paramour hit the mother a lot, police had been to the home, and she had to call police at least once. She was observed to have old scars on her arm. The 6-year-old child reported he got placed in time out when he got in trouble, he denied he had seen his mother and the paramour argue, and he denied police had been to the home. The 9-year-old sister reported she was grounded when she got in trouble, she denied she had seen her mother and the paramour fight, and she denied anyone hit her. She stated police had been to the home to check on her and her siblings. She was also observed to have old scars on her arms. The CPI met with the mother who reported she was no longer in a relationship with the paramour. She denied any domestic violence and denied she or the paramour had ever hit the children. In December 2021, DCFS indicated the investigation with the rationale that one child disclosed the mother and paramour fought in front of the children.

Child No. 22	DOB: 03/2022	DOD: 03/2022	Homicide
Age at death:	0 days		
Cause of death:	Prematurity due to maternal blunt force injury due to assault		
Alleged perpetrator:	Child's father		
Reason for review:	Open placement case and pending child protection investigation at time of child's death; two indicated child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn's mother presented at the hospital to seek treatment for her injuries following a domestic violence incident with the newborn's father. Hospital staff confirmed the mother was 25 to 26

weeks pregnant and performed an emergency c-section. The newborn died approximately 20 minutes after her birth. The parents had a history of domestic violence and drug use, the newborn's older siblings had been removed from their care, and the parents did not engage in recommended services. The father has been charged with aggravated battery to a pregnant person and murder. DCFS investigated the newborn's death and indicated the father for death by abuse and the mother for death by neglect.

Reason for Review: The newborn's older siblings, then ages 3, 4, and 6 years old, had been placed with their maternal grandparents since 2020. In May 2021, DCFS received a report that the mother gave birth at home, had three other children in DCFS care due to domestic violence, and the parents had engaged in a physical altercation one week earlier. The family's caseworker stated she knew the mother was pregnant and due in June 2021; the mother denied she was still in a relationship with the father. The caseworker called the mother who reported a friend was driving her out of state, and she had the baby with her. The next day, the Area Administrator determined the case would be screened with the State's Attorney. Two days later, the mother reported she had returned to Illinois, but neither the CPI nor the police could locate her. The court granted DCFS temporary custody of the baby, and a child protection warrant was issued for the infant. In June 2021, DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. One week later, the mother and baby were found, and the baby was admitted to the NICU. Two weeks later, the baby was discharged into foster care. In July DCFS opened an investigation on the grandparents. The children were removed after the grandfather tested positive for cocaine. In January 2022, the placement worker documented recommended services included substance use assessment, domestic violence services, and parenting classes but the parents had only engaged in services sporadically and the mother experienced housing instability. The 8-year-old sister refused visits with her parents, but the mother had visits with the other children. In February 2022, DCFS opened an investigation after receiving a report that the children's maternal grandparents used corporal punishment when the children had been placed with them. The investigation remained pending at the time of the newborn's birth and death. DCFS later indicated the maternal grandparents for substantial risk of physical injury/environment injurious to health and welfare by abuse.

Child No. 23	**DOB: 06/2015**	**DOD: 03/2022**	**Homicide**
Age at death:	6 years		
Cause of death:	Multiple gunshot wounds to the head and chest		
Alleged perpetrator:	Child's father		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-year-old and his mother were shot by the child's father, who then shot and killed himself. The child was pronounced deceased at the scene. Two days later, his mother died at the hospital. DCFS did not investigate the child's death.

Reason for Review: In June 2021, DCFS received a report that the child witnessed his father attack his mother, resulting in her being injured. The CPI observed the child with no signs of maltreatment. He stated the incident was not the first time he had seen his father punch his mother. The mother admitted she and the father had a long history of unreported domestic violence, she was afraid of the father, and the child had witnessed a domestic altercation. The father admitted to a verbal altercation but denied a physical altercation and stated he would never harm the mother in front of the child. The father refused to provide his location during the investigation. At case closure, the parents were not living together. The child stated he did not see his father, but spoke to him sometimes, and he felt safe with his mother and maternal grandparents. The mother reported the father moved out of state. DCFS indicated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect and unfounded the child's mother for the same allegation. The family declined intact services.

Child No. 24	DOB: 11/2020	DOD: 03/2022	Homicide
Age at death:	16 months		
Cause of death:	Complications of multiple injuries due to child abuse		
Alleged perpetrator:	Child's mother and father		
Reason for review:	Child was a youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-month-old died at the hospital. Approximately one year earlier, he sustained head injuries from which he did not recover. He remained comatose and was eventually discharged from the hospital into a long-term care facility. Police arrested the mother. DCFS investigated the toddler's death and indicated the parents for death by abuse, head injuries by abuse, bone fractures by abuse, and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In March 2021, DCFS received a report that the then 4-month-old toddler was brought to the hospital with a potentially life-threatening head injury. The mother told hospital staff he appeared sweaty and was shaking after feeding, so she attempted CPR and called 911. Medical imaging revealed the toddler had bilateral subdural hemorrhages in his brain, numerous intra-retinal hemorrhages and a diffuse anoxic brain injury due to oxygen loss, which medical staff suspected was caused by abuse. The parents denied knowing what happened and the doctor stated the injury could have happened some time before symptoms appeared. The father stated that five days earlier, the toddler was crying more than usual, was vomiting, and constipated. The mother called his pediatrician and was told his condition, absent a fever, did not necessitate a visit and the parents should give the toddler a laxative. The father stated the infant continued to vomit and cried when he moved, as if he was in pain. He stated that three days before the report, they brought the toddler to the emergency room, where medical staff performed tests and discharged him. He stated the toddler continued vomiting but seemed to be improving. The CPI initiated a safety plan with the toddler's then 2-year-old brother to be placed with his relatives. Additionally medical staff found the toddler to have multiple fractures which doctors opined were caused by a forceful back and forth movement of the back and neck. Physicians reported the toddler would remain comatose and the parents needed to decide about continuation or removal of care as the toddler could not breathe or eat on his own and required a trach and g-tube to be placed. The parents decided on continued care. The court granted DCFS temporary custody of the toddler and his brother. The brother remained with relatives. Later that month, DCFS indicated the parents for head injuries by abuse; bone fractures by abuse; and substantial risk of physical injury/environment injurious to health and welfare by neglect. In August 2021, the then was placed in a long-term care facility. In December 2021, the toddler was admitted to the hospital for respiratory issues. In February 2022, the parents signed a do not resuscitate order.

Child No. 25	DOB: 12/2013	DOD: 03/2022	Homicide
Age at death:	8 years		
Cause of death:	Failure to thrive due to chronic malnutrition due to physical neglect and abuse		
Alleged perpetrator:	Child's mother and father		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Eight-year-old was found cold and unresponsive by his mother, who reported she checked on him around 2:00pm having not seen him since he went to bed around 8:00pm the night before. The mother reported she put the child in a warm bath, began CPR, and called 911. The child was transported to the hospital, where he was pronounced deceased several hours later. At autopsy, the child's body showed signs of starvation over multiple months as well as physical abuse. DCFS investigated the child's death and indicated the parents for death by abuse; torture; cuts, bruises, welts, abrasions, and oral injuries by abuse; tying/close confinement by abuse; failure to thrive; and substantial risk of physical injury/

environment injurious to health and welfare by neglect. The parents have been charged with murder and are awaiting trial.

Reason for Review: In 2017, the court granted guardianship of the child and his brother to their paternal grandmother after they had been removed from their parents. In August 2021, DCFS received a report that the paternal grandmother had allowed the child's 11-year-old brother to stay with his parents for the past year, because of the brother hurting the child. The grandmother had also left the child with his parents one month prior, when she had to travel for a family matter. When the grandmother returned, the parents refused to return the child to her care. The grandmother called police who informed the grandmother she would need to involve family court. The grandmother expressed concerns about the parents' ability to care for the children long term because of the parents' history of drug use and physical aggression toward the children. The CPI spoke with the grandmother, who verified the narrative but stated she did not want the children back. The CPI made multiple attempts to locate the family. The State's Attorney advised the CPI to work with police and make every effort to locate the family before a protective warrant could be requested. The father contacted the CPI and said they had moved out of state and refused to cooperate with DCFS or the police. The State's Attorney refused to send any court orders. The child protection supervisor waived the daily attempts to see the children and noted that DCFS obtained earlier court orders that stated the parents had been deemed fit in 2015, therefore the case would be closed due to misinformation. DCFS unfounded the investigation for environmental neglect. In February 2022, DCFS received a report with multiple concerns including domestic violence, substance use and child abuse and neglect. The child protection supervisor confirmed the children were not enrolled in school. The father reported the children were not in school because he did not have legal guardianship but denied all other allegations. The father reported they returned to Illinois one month earlier and attempted to establish guardianship. DCFS later received a related information alleging the mother refused to open the door for DCFS because the child had two black eyes. Eventually, the CPI met with the children. The brother reported he felt safe at home and stated he had lived with his parents for a few years because his grandmother did not want him, he did not miss going to school but would be okay with going back. He denied anyone hurt him or his brother. The CPI noted the child was thin and small in stature; the child stated he ate often but did not gain weight. He stated he felt safe at home and did not want to return to his grandmother's home. The parents stated they had not been able to take him to a doctor because they did not have guardianship. The children were assessed as safe and intact services were discussed. In March 2022, the paternal grandmother agreed to sign temporary guardianship paperwork. The CPI again offered the parents intact services who stated they would consider them. The investigation remained pending at the time of the death and temporary guardianship had not been finalized. DCFS later indicated the investigation against the parents.

Child No. 26	**DOB: 05/2003**	**DOD: 04/2022**	**Homicide**
Age at death:	18 years		
Cause of death:	Gunshot wound of head		
Alleged perpetrator:	Unknown		
Reason for review:	Deceased was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Eighteen-year-old was shot and killed in his apartment. He was pronounced deceased by responding paramedics. The teen lived alone at the time of his death. Police have made no arrests. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: The teen came into DCFS care at 15 years old, after he was admitted to a psychiatric hospital for physical aggression and continued to exhibit aggressive behaviors in the hospital, and his parents refused to pick him up. In the year before his death, the teen was working and began living in his own apartment through an independent living program for youth in care. In February 2022, the teen's placement worker learned the teen was behind in rent and bills. His caseworker completed multiple

applications to assist him with funds to prevent eviction. The next month, he moved to a transitional living program. His caseworker last met with him and spoke to him in the week before his death.

Child No. 27	DOB: 07/2004	DOD: 04/2022	Homicide
Age at death:	17 years		
Cause of death:	Gunshot wound of head		
Alleged perpetrator:	Unknown		
Reason for review:	Child was a youth in care and parent of a youth in care; one indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Seventeen-year-old was driving her car when an unknown vehicle approached and fired shots in her direction. The teen was taken to the hospital, where she later died of her injuries. DCFS did not investigate the teen's death.

Reason for Review: In September 2020, DCFS obtained temporary custody of the teen and the teen's then newborn child after the teen had run away from home, given birth, and refused to live with her mother. The teen refused to meet with the CPI. In December 2020, DCFS received a report that the teen's mother was using drugs, allowed a man to live in the home and have a relationship with the then 16-year-old teen. The CPI met with the teen's mother who reported the teen met her 22-year-old paramour the year before, she did not learn of the relationship until the teen was pregnant. The mother and other relatives reported they did not know where the mother lived. In February 2021, the CPI reached the teen by phone. The teen reported she was living with her paramour but refused to provide an address or meet with the CPI. In March 2021, the teen's mother contacted the CPI to report the teen was at her home along with her paramour. Police took the teen into custody after a domestic violence incident with the paramour. The teen was placed in an emergency shelter for six days, then placed with her maternal aunt. One week later, the maternal aunt reported the teen ran away with the paramour. In June 2021, DCFS indicated the paramour for sexual penetration. The allegations against the teen's mother were unfounded. The teen was indicated for substantial risk to her child. In July 2021, the teen's placement worker learned the teen was living in an unauthorized placement with another aunt and learned there was a warrant out for the aunt's arrest. Later that month, the teen informed her caseworker she was living with her mother. In August 2021, the court changed the teen's permanency goal to independence. In March 2022, after multiple failed attempts to meet with the teen, the court recommended the permanency goal for the teen's child to be changed to substitute care pending termination of parental rights.

Child No. 28	DOB: 08/2005	DOD: 04/2022	Homicide
Age at death:	16 years		
Cause of death:	Gunshot wound of the head		
Alleged perpetrator:	Unknown		
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 found with a gunshot wound to his head and was transported to the hospital, where he was pronounced deceased. No arrests have been made. DCFS did not investigate the teen's death.

Reason for Review: In October 2021, DCFS received a report that the teen presented at the hospital with a gunshot wound to his leg, and hospital staff were unable to contact the teen's grandmother, with whom he lived. That day, the CPI spoke to the grandmother, who reported a relative was on the way to pick the teen up from the hospital. At the hospital, the teen reported a bullet grazed his back but said he did not know who shot him. He stated he felt safe with his grandmother. Two days later, the CPI met with the family. The grandmother reported she was commuting to work by public transit when she learned of

the incident and arranged for a relative to pick the teen up at the hospital. The teen reported there had been a shooting in the neighborhood and he had been in the wrong place at the wrong time. The teen's 14-year-old brother also reported feeling safe with the grandmother. In December 2021, DCFS unfounded the investigation for inadequate supervision because the grandmother immediately arranged for an adult family member to meet the teen at the hospital.

Child No. 29	**DOB: 10/2001**	**DOD: 04/2022**	**Homicide**
Age at death:	20 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unrelated person		
Reason for review:	Deceased was a youth in care; pending child protection investigation at time of deceased's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-year-old entered a bar with intent to rob the patrons. The youth displayed a gun and an armed customer shot him multiple times. Emergency responders were unable to resuscitate the youth and he was pronounced deceased at the scene. At the time of his death, the youth was on electronic monitoring, but had been on run from his placement since December 2021. DCFS did not investigate his death.

Reason for Review: The youth came into DCFS care in September 2015 at the age of 13, after DCFS took protective custody because his maternal great-grandmother refused to pick him up from the hospital. Between 2015 and 2022, the youth often went on run and had multiple placements. He was ultimately placed in a transitional living facility and his goal was independence. However, the youth was uncooperative with services. In 2021 the youth was diagnosed with fluid around his heart and experienced a minor stroke. The placement file documented his health issues were a result of marijuana use. The youth did not follow through with his medical appointments. The youth maintained two jobs, reported weekly visits with his 4-year-old daughter and regular visits with his mother and maternal great-grandmother but often chose unauthorized placements. His placement worker documented regular attempts to contact the youth. Her last contact with him happened approximately six weeks before his death, while he was in the hospital due to his cardiac issues. In August 2021, DCFS received a report that another youth in care was being paid by staff at the youth's transitional living facility to oversee other residents in the program, including the deceased youth. The CPI interviewed residents, who denied being placed in caretaking roles and reported staff were always present. In October 2021, the CPI interviewed the youth, whose report corroborated other residents' reports. The investigation remained pending at the time of the youth's death. The investigation was later unfounded for inadequate supervision.

Child No. 30	**DOB: 12/2007**	**DOD: 05/2022**	**Homicide**
Age at death:	14 years		
Cause of death:	Gunshot wound of neck		
Alleged perpetrator:	Unrelated person		
Reason for review:	Child was a youth in care; one indicated and one unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old was shot in the neck during an alleged attempted robbery, with two other teenagers. He was transported to the hospital. Six days later, the teen was pronounced brain dead. The following day, he was removed from life support and died. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: The teen came into DCFS care in 2018, at 10 years old, and was placed in a group home. In June 2021, DCFS received a report that the teen and his then 14-year-old brother broke into their

mother's apartment and caused extensive damage leaving the apartment uninhabitable. The teen was arrested and released later that month. DCFS took the report as information only. In July 2021, the teen was arrested for robbing cars in a hotel parking lot. Upon his arrest, police found heroin and cannabis on him. In September 2021, the teen was released from juvenile detention on probation. The teen repeatedly went on run from his group home. In January 2022, the teen was arrested in another state for driving a stolen vehicle and fleeing police. He was detained, but charges were dropped. The teen was returned to Illinois. The teen continued to go on run. The teen was eventually placed with his paternal grandmother. The grandmother later requested his removal after he threatened to shoot her. The teen ran from the grandmother's home and went to his mother's home as an unauthorized placement. That month, the placement worker identified an out of state secured residential placement for the teen, who was placed on their waiting list. Two days later, DCFS received a report that the mother called police after an argument, the teen left, and she no longer wanted him in her home. The teen denied he ran away and stated he had been on the home's back porch. DCFS unfounded the investigation for lock out. The teen reported he wished to stay in his mother's home and refused to sign paperwork for the out of state placement. Later that month, the mother reported the teen had stolen money and expressed concern about the teen's behavior and disregard for rules. Three weeks before the teen's death, placement options were discussed at a child and family team meeting. The worker made plans to continue discussions in another meeting in June 2022. The teen died before the second meeting.

Child No. 31	**DOB: 12/2019**	**DOD: 05/2022**	**Homicide**
Age at death:	2 years		
Cause of death:	Multiple blunt injuries of the abdomen and chest		
Alleged perpetrator:	Paramour of child's mother		
Reason for review:	Child was a youth in care and was the child of a youth in care; one indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old was found unresponsive by her 20-year-old mother, who had gone to wake her when a case aide arrived to transport the toddler to daycare following an overnight visit in the mother's home. The case aide called 911 and the toddler was transported by ambulance to the hospital, where she was pronounced deceased upon arrival. The mother's 5-week-old infant had been allowed to remain in her care. The mother's paramour, the newborn's father, was on probation for assault and was not allowed to be around the children. The mother admitted she had allowed the paramour to come to the home and left the children alone with him. The paramour confessed to killing the toddler and is awaiting trial for first degree murder. DCFS indicated the paramour for death by abuse and indicated the mother for death by neglect; DCFS also indicated the mother and the paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect. The toddler's half-sister came into care and was placed in a traditional foster home.

Reason for Review: The toddler's mother came into DCFS care when she was 2 years old and was later adopted. At 16 years old, the mother returned to DCFS care through a dependency petition after she repeatedly ran away from home and her adoptive parents reported she needed more services than they could provide. DCFS learned the mother was pregnant with the toddler and she was placed in a residential maternity program. In December 2019, the toddler was born. In April 2020, DCFS was granted temporary custody of the then 4-month-old toddler, after the mother left the placement without permission and took the baby with her. Other concerns were also voiced about the mother's ability to care for the baby who was placed in a traditional foster home. The mother began participating in services and making progress but in April 2021, DCFS opened an investigation after the mother took the toddler on an unauthorized visit. Following the incident, the mother's visits were decreased. In June 2021, DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. The mother had regular visits with the toddler and participated in services. In October 2021, the mother

disclosed she was pregnant with the toddler's half-sister. The mother reported she and the paramour planned to live separately. The mother was placed in a pregnant and parenting teen group home, attended prenatal appointments, had supervised visits with the toddler, and worked on obtaining housing, employment, and education. She was inconsistent in attending a weekly substance treatment program and tested positive for THC. She later reported she stopped using marijuana during her pregnancy. In December 2021, the mother was granted unsupervised visits because she was making progress in her service plan. In February 2022, the caseworker made multiple attempts to engage the paramour in services. A background check revealed the paramour had a 2018 conviction for assault of a pregnant person. Case notes documented that he participated in a domestic violence assessment but was determined not to need services, and he was referred for a mental health assessment. In March 2022, the mother moved into her own apartment and the duration of her visits with the toddler increased. That month, the mother gave birth to the toddler's half-sister and DCFS opened an investigation because she had a child in care of DCFS. Her caseworker's supervisor reported the mother had successfully completed services in the teen parent program and the only concern was the paramour, who had been added to the service plan but had not completed services. The mother denied the paramour lived in the home. The State's Attorney reported no concerns about the safety of the half-sister in the mother's home and stated the mother had been informed the father could not have contact with the toddler. In April 2022, while the investigation was pending, the mother asked the caseworker if the paramour could be present for unsupervised overnight visits. Five days later, a service provider reported they thought the paramour was staying at the home. At court the next day, the workers reported they wanted to staff the case before making a recommendation to grant overnight visits, but the judge ordered overnight visits. Before the toddler's first overnight visit with the mother, the caseworker conducted an unannounced visit and noted the toddler had a cut on her head, which the mother stated was from her hair being braided too tightly. The worker advised the mother to make a doctor's appointment to ensure it was healing correctly. Two days later, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. The next day, approximately one week before the toddler's death, the mother contacted her caseworker to ask for approval to allow the paramour to be present for overnight visits. The worker informed the mother he could not be present because he had not completed services.

Child No. 32	**DOB: 09/2005**	**DOD: 05/2022**	**Homicide**
Age at death:	16 years		
Cause of death:	Gunshot wound of the head		
Alleged perpetrator:	Teen's boyfriend		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old, sustained gunshot wounds to the head and was transported to the hospital, where she remained on life support for four days before she was pronounced deceased. The shooting occurred at the home of the teen's 19-year-old boyfriend, who lived with his mother. The boyfriend initially reported the teen shot herself. Police reported that the teen and the boyfriend had a history of domestic violence, and the boyfriend had a criminal history that included weapons violations. Police arrested and charged the boyfriend for destruction of evidence. DCFS investigated the teen's death and indicated the boyfriend for death by abuse; DCFS unfounded the teen's foster parent for death by neglect and inadequate supervision.

Reason for Review: The teen and her three siblings came into DCFS care in 2019 during an investigation in which her mother was indicated for cuts, bruises, welts, abrasions, and oral injuries by abuse; and substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect. In July 2021, the teen was placed in a relative foster home, and she remained in this placement until her death. In September 2021, the teen enrolled in high school and her foster parent reported she was attending school and appeared to be stable. The family's placement worker continued to monitor the

children and attempted to meet with the mother. Fifteen days before the teen's death, her foster parent gave the placement agency a 14-day notice for the removal of the teen from her home. She stated the teen and her 19-year-old sister attacked their mother, the teen would not cooperate with services or anything that was asked of her, and she could no longer manage them in her home.

Child No. 33	**DOB: 03/2014**	**DOD: 05/2022**	**Homicide**
Age at death:	8 years		
Cause of death:	Multiple injuries due to assault		
Perpetrator:	Child's mother		
Reason for review:	Pending child protection investigation within one year of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Eight-year-old was discovered deceased in bed, with her mother next to her. The child's mother admitted to suffocating her. The mother has been charged with first degree murder. The DCFS investigation into the child's death remains pending.

Reason for Review: In March 2022, DCFS received a report that the child's mother struck her father in the face numerous times while the child was present, the mother was intoxicated during the altercation, and she had a history of using phencyclidine (PCP). Police responded and allowed the mother to leave with the child. The next day, the CPI made a good faith attempt to see the child and documented no further attempts for nearly two months. Six days before the child's death, the investigation was re-assigned. The day before the child's death, the CPI met with the child and her mother. The mother reported the child's father tried to kill her. She stated the day of the incident, he attempted to push her out of his car while he was driving, she hit him to get him to stop, and police were called and instructed them to separate, and no arrests were made. The mother denied using PCP and agreed to complete a toxicology screening. The child reported she was in the car with her parents, who were hitting and screaming at each other, and when her father parked the car, her mother told her to get out of the car and run, but she was afraid, so she did not. The child reported she felt safe with her mother and was observed to be clean and free of visible marks or bruises. She was assessed as safe in her mother's home. The investigation remained pending when the child was found deceased. DCFS later indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 34	**DOB: 09/2006**	**DOD: 06/2022**	**Homicide**
Age at death:	15 years		
Cause of death:	Gunshot wound of the head		
Alleged 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 was found in an alley with a gunshot wound to the head around 6:00am. Emergency services pronounced the teenager deceased at the scene. Police reported no known motive for the shooting at the time of the teen's death. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In December 2021, DCFS received a report that the teen had been detained for trespass of a vehicle and the family would not retrieve the teen from the police station. The teen stated he had been kicked out of his father's home in July 2021 and he refused to go to a shelter. The teen fled after he was transported to his father's home. The father reported having trouble with the teen's behavior and stated he was the teen's only support since the teen's mother died several years earlier. He denied locking the teen out and stated the teen chose to leave because he did not want to follow rules. Law enforcement confirmed the family filed a missing person report in July 2021. The teen's 13-year-old brother reported the teen caused trouble. In January 2022, the teen was arrested for weapons possession. In February 2022,

the father stated concerns about the teen's gang affiliation, and the teen stealing a gun. A collateral contact reported no concerns about the teen's father or stepmother and stated they repeatedly tried to help the teen. DCFS unfounded the investigation for inadequate supervision and lockout.

Child No. 25	**DOB: 08/2017**	**DOD: 06/2022**	**Homicide**
Age at death:	4 years		
Cause of death:	Multiple injuries due to child abuse		
Alleged perpetrator:	Paramour of child's mother		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Full investigation pending		

Narrative: Four-year-old was transported by ambulance to the hospital, where she was pronounced deceased. The child had been in the care of the mother's paramour while the mother was at work. The paramour stated the child fell out of bed and was breathing heavily. Emergency responders reported the child had foam around her nose, lacked a pulse, and was not breathing. At the hospital, the child was observed to have bruising to her arms, legs, and temple; an abrasion on her nostril; and a burn mark on the top of her foot. DCFS investigated the child's death and indicated the paramour for death by abuse and indicated the mother for death by neglect.

Reason for Review: Twelve days before the child's death, DCFS received a report the child had presented at the hospital with unusual pattern burns to her hands, feet, and both elbows; the mother told hospital staff the child sustained the burns four or five days earlier during a bath, because the child turned on the hot water when the mother left the bathroom for a few minutes. The mother said she attempted to treat the burns at home but brought the child to the hospital because her foot was not healing. The reporter noted there were no burns on the child's back, buttocks, or legs. The CPI met with the family at the hospital. The mother stated she was bathing the child while cooking and left the bathroom to check on the food. She returned to the bathroom when she heard a scream and saw the child had turned on the hot water. She stated she did not see any skin coming off, and she looked up how to treat the burn at home. She brought the child to the hospital because the burn had not improved. The CPI attempted to interview the child, who stated the burn did not hurt, but otherwise did not understand her questions. The mother identified her paramour as her only source of support; she told the CPI the paramour was a friend. The child was discharged to the mother's paramour under an out-of-home safety plan. The child's treating physician reported concern about the mother's delay in seeking treatment given the severity of the burn but stated she could not state the delay on its own was abuse or neglect. The physician stated the child's injuries did not align with the mother's account of the incident. Two days before the child's death, DCFS terminated the safety plan, and the child was returned to her mother's care. At the time of the child's death, the investigation remained pending. DCFS later indicated the mother and her paramour for burns by abuse.

Child No. 36	**DOB: 12/2021**	**DOD: 06/2022**	**Homicide**
Age at death:	5 months		
Cause of death:	Gunshot wound of head		
Alleged perpetrator:	Unknown		
Reason for review:	Open intact family services case at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-month-old was shot and killed while riding in a car with her mother, father, and a sibling. The parents began driving erratically because they believed they were being followed. Multiple gunshots hit the car and the infant was hit in the forehead. The infant was taken to the hospital, where she was pronounced deceased. DCFS did not investigate the infant's death.

Reason for Review: In September 2021, DCFS received a report that the infant's mother and father had been fighting. DCFS took the report as a child welfare services referral but were unsuccessful in contacting the mother. In April 2022, DCFS received a report that the infant's parents were engaged in frequent domestic violence in the presence of the children, and the infant's mother had an order of protection against the father but allowed him in the home. The mother denied any recent domestic violence and stated the infant's father did not live in the home. The mother reported she had a restraining order against the father and called law enforcement to remove the father from the home in the previous month. The mother stated the incidents with the father were verbal only and the children were never injured during the arguments. The CPI interviewed the siblings. The 9-year-old maternal half-sister reported the infant's father lived in the home and she had witnessed him punching, choking, and throwing her mother; he had almost hit her once when she told him not to hit her mother; and he had once hit her brother. The brother reported the father lived in the home, punched his mother in the head, and beat him up when he did something bad. During a home visit, an unidentified man was present, and the mother refused to provide information on him. The CPI determined the man was the infant's father, who had an extensive criminal record, including 13 charges and one conviction for assault. The CPI implemented a safety plan for the children to stay with mother's cousin. The mother agreed to intact family services. In May 2022, the CPI informed the mother the order of protection was no longer valid because of her missed court date and referred her to a victim services and therapy program. The children reported they felt safe and were free of any signs of abuse. In June 2022, the CPI interviewed the father, who reported he was co-parenting but not in a current relationship with the mother. He admitted to anger issues and past domestic violence incidents but stated no one was injured. DCFS indicated both parents for substantial risk of physical injury/ environment injurious to health and welfare by neglect. Three weeks before the infant's death the intact family case opened. The mother agreed to engage in recommended services, including domestic violence and parenting services. The father refused services. The intact worker made additional attempts to see the family before the infant's death but was only able to speak with them by video conference. Two days before the infant's death, the intact worker shared concerns with her supervisor, and made an unsuccessful unannounced visit to the home the next day.

SUICIDE

Child No. 37	DOB: 08/2005	DOD: 12/2021	Suicide
Age at death:	16 years		
Cause of death:	Asphyxia due to hanging		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Child No. 38	DOB: 01/2004	DOD: 12/2021	Suicide
Age at death:	17 years		
Cause of death:	Contact gunshot wound of head, significant contributing condition of history of substance abuse		
Reason for review:	Three unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Child No. 39	DOB: 11/2006	DOD: 12/2021	Suicide
Age at death:	15 years		
Cause of death:	Self-inflicted gunshot wound to the head		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Child No. 40	DOB: 02/2003	DOD: 01/2022	Suicide
Age at death:	18 years		
Cause of death:	Toxicity of fentanyl and methamphetamine due to fentanyl and methamphetamine abuse		
Reason for review:	Deceased was a youth in care		
Action Taken:	Investigatory review of records		

Child No. 41	DOB: 01/2010	DOD: 04/2022	Suicide
Age at death:	12 years		
Cause of death:	Asphyxia due to hanging		
Reason for review:	Closed intact family services case and two indicated child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Child No. 42	DOB: 07/2010	DOD: 06/2022	Suicide
Age at death:	11 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		

UNDETERMINED

Child No. 43	DOB: 04/2017	DOD: 08/2021	Undetermined
Age at death:	4 years		
Cause of death:	Gunshot wound of chest		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-year-old was shot in the chest when her 8-year-old brother pulled an unsecured firearm from the grasp of her 6-year-old sibling to return it to the bag the 6-year-old took the firearm from. The child was transported to the hospital by ambulance, where she was pronounced deceased. At the time of her death, she and three of her siblings were in the care of their uncle while their mother, her paramour, and their infant brother were at the hospital with their 2-year-old brother. The mother knew the uncle owned a handgun. The uncle stated he normally kept the gun in the trunk of his car but that day, he accidentally brought the bag that contained the gun into the residence and placed it on the couch with a pillow over it. He stated he then walked to the back of the apartment to lock the door when he heard one gunshot. Police arrested the uncle for child endangerment. DCFS investigated the child's death and indicated the uncle for death by neglect.

Reason for Review: In August 2020, DCFS received a report that the mother's paramour, father of the deceased child's youngest sibling, threatened the father of the deceased child and the child's older siblings with a firearm after the older children's father confronted the paramour about spanking the children. The reporter further expressed concern for the then 1-year-old brother, who has asthma, because the week prior, the mother did not immediately seek care when he had a fever. When the mother did bring him to the emergency room he was diagnosed with pneumonia and admitted to the hospital. The reporter also shared concerns about the mother's mental health. The mother denied the allegations and told the CPI that the father of the older children was abusive, angry that she left him, and she planned to get an order or protection. She stated the 1-year-old was admitted to a children's hospital and the hospital continued to monitor the child as he was diagnosed with a heart condition. The children were assessed as safe, the home was observed to be appropriate and had appropriate sleeping arrangements. The mother obtained an order of protection against the father of the older children who she identified as the aggressor. The mother's paramour denied the allegations and stated the father of the older children confronted him. The CPI observed the children multiple times throughout the investigation and observed no signs of abuse or neglect. DCFS indicated the mother's paramour for substantial risk of physical injury/environment injurious to health and welfare by abuse due to evidence the incident occurred and the paramour's criminal history. DCFS unfounded the mother for medical neglect.

Child No. 44	DOB: 06/2021	DOD: 08/2021	Undetermined
Age at death:	7 weeks		
Cause of death:	Undetermined (infant with pneumonia found unresponsive in inappropriate sleeping environment)		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-week-old was found unresponsive while co-sleeping with his parents, who called 911. The infant was transported by ambulance to the hospital, then transferred to a children's hospital. He was pronounced deceased the next day, after he was removed from life support. DCFS investigated the infant's death and unfounded the parents for death by neglect but indicated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In February 2021, DCFS received a report that the 20-year-old mother and her 14-year-old sister, the infant's maternal aunt, were involved in a physical fight during which the mother hit the aunt on the head with a phone. The CPI made good faith attempts to see the children at home and at the aunt's school, but the school reported the aunt was enrolled in remote learning and they had no specific concerns about the aunt's wellbeing. In March 2021, the CPI met with the family at home. Family members reported the maternal grandmother was home during the incident, and the infant's mother was not in a caregiving role at that time. The maternal grandmother and the infant's 13-year-old maternal aunt broke up the fight. The children all stated they felt safe at home and were observed to be free of visible marks or bruises. In April 2021, the family reported the mother moved out of the maternal grandmother's home. DCFS unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse to the 14-year-old aunt by the infant's mother.

Child No. 45	**DOB: 06/2021**	**DOD: 08/2021**	**Undetermined**
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Two-month-old was found unresponsive and cold to the touch in an adult bed with her parents. The infant's mother called 911 and the infant was transported by ambulance to the hospital, where she was pronounced deceased upon arrival around 9:00am. The mother reported she had fed the infant around 1:00am and laid her down to sleep. The mother admitted to using marijuana but denied using the night prior to the infant's death. DCFS investigated the infant's death and unfounded the investigation for death by neglect.

Reason for Review: In January 2021, DCFS received a report that the home had dirty diapers and old food throughout the home, dirty dishes in the sink, and squirrels in the home. The reporter added that the mother continued to use marijuana and drink while pregnant with the infant. The CPI documented multiple attempts to contact the family. In April 2021, the CPI received a call from the reporter, who recanted the report and stated he called the Hotline to retaliate against the mother. The next day, the CPI made in-person contact with the family, documented the infant's then 9-month-old and 2-year-old siblings were free of any marks or bruises, and did not observe any food left out in the home. The mother denied the allegations of squirrels coming into the home. The mother's landlord reported the mother had been a good tenant and stated squirrels had been making a nest in the side of the home but denied problems inside the home. DCFS unfounded the investigation for environmental neglect. One week after the infant's birth, DCFS received a report that the home had garbage piled up, an insect infestation, spoiled food, and a bad odor. In addition, the father, a convicted felon, was verbally abusive to the 2-year-old sibling, verbally and physically abused the mother in front of the children and left a gun within reach of the children. The CPI documented four good faith attempts to see the family before the infant died and the investigation remained pending at the time of the child's death. The CPI later observed the home to be in deplorable condition and indicated the investigation for environmental neglect and unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 46	DOB: 08/2021	DOD: 08/2021	Undetermined
Age at death:	2 weeks		
Cause of death:	Unexplained sudden death (extrinsic factors identified)		
Reason for review:	Open intact family services case at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-day-old was found unresponsive around 5:00am, with blood coming from his nose and mouth, after his father fell asleep while holding him. His mother attempted to wake him up and began CPR, and his father called 911. The newborn was transported to the hospital by ambulance, where he was pronounced deceased. The newborn's paternal grandmother had been watching the newborn the evening before, until his parents picked him up at 1:00am. DCFS investigated the infant's death and unfounded the newborn's parents for death by neglect.

Reason for Review: In March 2021, DCFS received a report that the newborn's then 15-year-old mother was residing with the infant's then 18-year-old father, when the mother became pregnant by the father. The reporter stated the newborn's maternal grandmother changed the mother's address with her school and gave the newborn's paternal grandmother guardianship of the mother. The reporter also noted the paternal grandmother's home was the safest place for the mother to stay, because the maternal grandmother had been using drugs and planned to leave the state. The mother reported she had lived with the father for nine months, because she did not feel safe at home, and her school and the newborn's paternal grandmother were helping her with emancipation. The paternal grandmother reported the mother and father began dating when the father was 17 years old, and she explained the consequences of their age difference when he turned 18, but the father ran away and refused to come home without the mother due to the mother's home situation. She stated the mother's room was on a different floor than the father's room, and she did not know the mother had been going to the father's room until the mother became pregnant. The parents attended parenting classes and prenatal appointments. The parents agreed to intact services, which began in April 2021. The State's Attorney declined to file charges because the father was 17 years old when he and the mother began their relationship. In May 2021, DCFS unfounded the father and his parents for sexual penetration. In June 2021, the father graduated high school and the parents moved into a residence with the paternal uncle and uncle's paramour. The intact worker noted no concerns with the home. The mother received a car seat and crib from her school. The intact worker provided baby clothes, information on legal assistance for the mother's emancipation, and confirmed the parents attended parenting classes. After the newborn's birth in August 2021, the intact worker observed the newborn's nursery and crib, discussed safe sleeping practices with the parents, observed the infant to appear healthy, observed the mother to be doing well with the newborn, and discussed plans for the mother's return to high school. The intact case remained open at the time of the newborn's death.

Child No. 47	DOB: 08/2021	DOD: 08/2021	Undetermined
Age at death:	2 weeks		
Cause of death:	Undetermined due to no traumatic injury or natural disease found at autopsy; significant contributing condition of co-sleeping with adult and child		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-week-old was found unresponsive by his mother, who had been co-sleeping with him. The mother stated she nursed him around 4:00am then dozed off. The mother called 911 and paramedics transported the newborn to the hospital, where he was pronounced deceased. The newborn had been born with jaundice, but his levels were normal at his follow-up appointment, and his pediatrician said he was a healthy baby. DCFS unfounded its investigation of the newborn's death because the autopsy showed no evidence of abuse or neglect.

Reason for Review: In November 2020, DCFS received a report that the mother contacted police because the father committed aggravated battery against the newborn's then 13-year-old half-brother earlier that month. The mother stated she did not call police instantly because the father threatened her. The mother stated she did not seek medical attention for the 13-year-old because she did not think his injuries were severe. When police responded they did not observe any injuries. On the day of the DCFS report, the CPI observed the children in the home, saw no physical signs of abuse or neglect, and observed the home to be safe. The mother told the CPI that the father and the 13-year-old were play-fighting and she told them to stop. The mother told the CPI she made the report after she ran into the father the night before and he cursed at her. The 13-year-old stated his fight with the newborn's father started as play but turned into an altercation which the mother broke up, and he had not seen the newborn's father since. He denied being afraid of anyone in the home. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse and neglect.

Child No. 48	**DOB: 05/2021**	**DOD: 09/2021**	**Undetermined**
Age at death:	4 months		
Cause of death:	Sudden unexpected infant death with co-sleeping		
Reason for review:	Open high-risk intact family services case and three pending child protection investigations at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old was found unresponsive at home around 5:00am by her mother's paramour. The mother began CPR and the paramour called 911. The infant was transported to the hospital by ambulance. She had last been seen alive approximately two hours earlier when her mother gave her a bottle and fell asleep while feeding her. DCFS investigated the infant's death and indicated her mother for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant's three siblings.

Reason for Review: In May 2021, DCFS opened an investigation after receiving a report that the infant's mother tested positive for amphetamines when the infant was born. DCFS initiated a safety plan in which the mother was not to have unsupervised contact with the children. The mother stated she took the maternal grandmother's Adderall by mistake, believing the blue pills were Excedrin, and she did not know she took the wrong medication until several hours later. The maternal grandmother stated she told the mother to look for headache medication in her pill bottle when the mother reported a headache but did not warn the mother that she had her prescription medication mixed in with other pills. The infant's mother denied drug use and agreed to participate in intact family services. She agreed to toxicology screenings and a mental health and substance use assessment prior to ending the safety plan. DCFS terminated the safety plan one month after the investigation opened, after the mother met the requirements. The CPI documented speaking with the mother about safe sleeping practices. The investigation remained pending at the time of the infant's death. The investigation was later indicated for substantial risk of physical injury/ environment injurious to health and welfare by neglect. In August 2021, DCFS opened another investigation after receiving a report that the family's apartment was in deplorable condition, including fecal matter on the floor and walls, vomit on mattresses, mold growing in the home, and trash throughout the home. The mother agreed to allow the maternal grandmother to care for the children under a safety plan. The mother denied the allegations but would not allow the CPI to enter the home. The CPI though documented discussing safe sleep practices with the mother. Three days later, the CPI returned to the home which had been cleaned. The CPI saw the children at their maternal grandmother's home. The children's pediatrician did not have concerns about the family. The mother completed a mental health assessment, and the provider made no recommendations. The investigation remained pending at the time of the infant's death and was later indicated for environmental neglect. In mid-August 2021, the transitional visit for intact family services occurred. Three days later, DCFS opened another investigation after receiving a report that the infant's 2-year-old, 3-year-old, and 4-year-old siblings were alone outside the home and all

three were dirty with wet diapers. The CPI documented a good faith attempt to see the family that day. Four days before the infant died, the CPI observed the family at the maternal grandmother's home. The investigation remained pending at the time of the infant's death and was later indicated for inadequate supervision. The family's intact family worker identified needed services including an additional mental health and substance use assessment, random toxicology screenings, and parenting classes. Intact workers observed the children on multiple home visits, noting the children appeared safe, and documented safe sleeping arrangements for all children.

Child No. 49	**DOB: 12/2019**	**DOD: 09/2021**	**Undetermined**
Age at death:	21 months		
Cause of death:	Drowning		
Reason for review:	Open intact family services case at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-one-month-old was found face down in a bathtub by her mother, who called 911. The toddler was transported by ambulance to the hospital, where she was pronounced deceased. The mother reported she had bathed two of the toddler's older siblings and left the bathtub unattended for approximately two to three minutes after taking them out of the bath to tend to another sibling. She returned to the bathroom and found the toddler face down and unresponsive. The mother stated the toddler had started walking the week prior and had gotten into the bathtub by herself. Police officers who responded to the scene stated the home was very dirty and the father fled when they arrived because he had multiple arrest warrants. The mother stated the father was in the home but did not live there. DCFS investigated the toddler's death and indicated the mother for death by neglect, inadequate supervision, and environmental neglect.

Reason for Review: In June 2021, DCFS received a report that the children were frequently unattended and running around naked outside. The next day, the CPI met with the family and documented the toddler and her five siblings, between the ages of 2 months and 8 years, were dirty and unbathed; the home was filled with garbage and there was old food on the floor; and the mother was growing marijuana plants in the home. The toddler's then 2-month-old sister was observed sleeping on a mattress with blankets and pillows, in a locked room. DCFS took protective custody of the children, but the court returned the children to their mother's care under court supervision and DCFS opened an intact family services case. DCFS indicated the mother for inadequate supervision and environmental neglect and indicated both parents for substantial risk of physical injury/environment injurious to health and welfare by neglect. The intact worker reported the parents were cooperative with services. The intact worker recommended substance use assessment, parenting classes, and domestic violence services. The mother reported she installed a new alarm system to prevent the children from opening the back door. The intact worker observed blankets in the 2-month-old's crib and discussed safe sleep with the mother multiple times throughout the case. The mother reported the father did not live in the home, but he was often present when the intact worker visited. The mother was engaged in parenting classes, the toddler was engaged in physical therapy, the toddler's oldest siblings began school, and the toddler's 4-year-old brother was on the waitlist for daycare. The intact worker documented the home was sometimes appropriately clean and at other times, the home was in disarray. One day before the toddler's death, the intact worker observed the home and did not document any safety concerns, and the younger children were observed asleep in appropriate sleeping arrangements.

Child No. 50	DOB: 06/2020	DOD: 11/2021	Undetermined
Age at death:	17 months		
Cause of death:	Cardiopulmonary arrest due to possible hypothermia		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-month-old was found in a retention pond in a neighboring state. The day before, DCFS received a report that the mother was found murdered at home and the toddler was missing. Illinois State Police issued an endangered missing person advisory. The mother's on-and-off paramour was arrested and charged with the murder of the toddler's mother. There are no formal charges in the toddler's death. DCFS investigated the toddler's death and indicated the paramour for death by abuse.

Reason for Review: In November 2020, DCFS opened an intact family services case for the toddler's mother after indicating the mother for medical neglect because the toddler was born with slow uterine growth disorder and had missed her follow-up appointment. The family's intact family services case included recommendations for individual therapy, parenting classes, and ensuring the mother followed up on the toddler's medical treatment. The mother was compliant with services, attended all medical appointments, and completed parenting classes. The intact worker made regular announced and unannounced visits and assessed the home of the mother and the toddler's maternal grandparents, who often watched the toddler while the mother worked, as safe. In March 2021, DCFS successfully closed the intact family services case.

Child No. 51	DOB: 06/2020	DOD: 11/2021	Undetermined
Age at death:	16 months		
Cause of death:	Undetermined		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: One-year-old was found unresponsive by the grandmother. Paramedics noted the toddler was cold to the touch, and had dried blood on his nose, mouth, and fingers, as well as scratch marks from his neck to his belly button. DCFS investigated the toddler's death and unfounded the investigation against the toddler's mother for death by abuse because law enforcement found no evidence the toddler's parents contributed to his death.

Reason for Review: In September 2021, DCFS received a report that the parents used drugs in the presence of the toddler and engaged in domestic violence when under the influence. The reporter also alleged that the parents left the toddler in the care of the paternal grandmother who also used drugs, and the home had animal feces. The CPI visited the family and noted the toddler appeared healthy, with no signs of abuse or neglect, and the home was free of any environmental concerns. The toddler's mother denied anyone in the home used drugs, as did the toddler's 16-year-old maternal uncle, who lived in the home. The investigation was pending at the time the toddler died. The investigation was later unfounded against the toddler's mother and father for environmental neglect, inadequate supervision, and substantial risk of physical injury/environment injurious to health and welfare by neglect because the home appeared clean during an unannounced visit and the parents and uncle denied anyone in the home had issues with substance misuse.

Child No. 52	DOB: 08/2008	DOD: 12/2021	Undetermined
Age at death:	13 years		
Cause of death:	Gunshot wound of head		
Reason for review:	Child was a youth in care within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old was brought to the emergency room with a gunshot wound of the head. He was pronounced deceased later that day. The teen had been living with his maternal great aunt. The teen's 11-year-old brother reported their adult cousin, who also lived in the home, accidentally shot the teen. An unlocked gun box and ammunition were found in the cousin's room and the cousin was arrested. DCFS investigated his death and indicated his cousin for death by abuse and wounds by abuse; DCFS indicated his maternal great aunt for wounds by neglect and inadequate supervision.

Reason for Review: In 2016, DCFS took protective custody of the then 7-year-old teen and his then 6-year-old brother. They were placed with their great aunt and remained in her foster home throughout the case with a permanency goal of guardianship. The placement worker made regular monthly visits with the family. In March 2021, the maternal great aunt obtained subsidized guardianship and DCFS closed the placement case.

Child No. 53	DOB: 11/2021	DOD: 01/2022	Undetermined
Age at death:	5 weeks		
Cause of death:	Sudden unexplained infant death, significant contributing condition of unsafe sleep environment		
Reason for review:	Three unfounded and one indicated child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-week-old was found unresponsive by his mother and maternal grandmother. The mother called 911 and the infant was transported by ambulance to the hospital, where he was pronounced deceased. The grandmother had been watching the infant and his 2-year-old maternal half-sister, while his mother was at a relative's home. When the mother returned, the grandmother placed the infant on a Boppy pillow on his mother's bed. The mother reported she fed and burped the infant, then placed him back on the Boppy pillow to sleep. DCFS investigated the infant's death and unfounded his mother for death by neglect. The rationale noted the Boppy pillow company had recently issued a recall due to eight reports of babies suffocating while using their product.

Reason for Review: In December 2020, DCFS received a report of a domestic violence incident between the maternal grandmother and the grandmother's paramour while a then 1-year-old sibling was present. Police arrested the paramour; they observed no marks or injuries to the sibling or the grandmother. That day, the CPI met with the grandmother and sibling at the home. The grandmother reported she had been involved with the paramour for seven months and there had been no prior domestic violence incidents. The grandmother reported she ended the relationship. The CPI provided a pack-and-play because there were no safe sleeping arrangements in the home, and the grandmother stated she often cared for the sibling. In January 2021, DCFS indicated the paramour for substantial risk of physical injury/ environment injurious to health and welfare by abuse. DCFS unfounded the maternal grandmother. In April 2021, DCFS received a report that the mother sent a text message saying she was going to jump off a bridge with the infant's sibling. Emergency medical services assessed the mother and determined she was not suicidal. The CPI met with the family at the home, and the mother stated she sent the text message one year earlier because she was angry with the sibling's father. She admitted to past mental health concerns but reported no recent issues. Multiple contacts confirmed the mother's report that she had sent the text message one year earlier, and they reported no concerns about her care for the sibling. In July 2021, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. In August 2021, DCFS received a report that the mother was having a

mental health crisis. The reporter further expressed concern that the mother had engaged in criminal activity, used drugs, and associated with dangerous men. The CPI met with the mother, who reported she was living with the maternal grandmother. The mother denied the allegations. She stated she was pregnant with the infant, and admitted to smoking marijuana due to nausea, but denied other drug use and completed toxicology screenings during her prenatal appointments. She stated the infant's deceased father had a child with another woman who had been threatening her. The CPI observed the sibling to have no signs of abuse or neglect and the home had safe sleeping arrangements. Collateral contacts reported no concerns. In October 2021, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect.

Child No. 54	**DOB: 01/2022**	**DOD: 01/2022**	**Undetermined**
Age at death:	11 days		
Cause of death:	Undetermined		
Reason for review:	Child was a youth in care; pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Eleven-day-old died at the hospital after being removed from a ventilator. On the day of his birth, his mother nursed him, and hospital staff found he had stopped breathing. He was transferred to the NICU and placed on a ventilator. He died after the mother signed a DNR (do not resuscitate) order and he was removed from the ventilator. Upon the newborn's death, DCFS added an allegation of death by neglect to the investigation that was pending at the time of the newborn's birth. The autopsy report noted suffocation could neither be confirmed nor ruled out. DCFS unfounded the investigation for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In 2019, DCFS took protective custody of the newborn's then 1-year-old, 4-year-old, and 6-year-old siblings. In 2020, the mother gave birth to a fourth sibling, and DCFS took protective custody of the sibling. The children were placed with their maternal uncle. In 2020, the mother signed consents to allow the three older children to be adopted. The placement worker advised the mother to re-engage in services if she wished to have the youngest sibling returned home. The mother made sporadic visits with the youngest sibling. In August 2021, the mother reported she was pregnant with the newborn but would not provide the father's name. In September 2021, the mother surrendered her parental rights to the newborn's then 16-month-old sibling. The family's placement worker continued to make regular contact with the children in the home of their maternal uncle, and noted the children consistently appeared happy. The maternal uncle hired an adoption attorney and obtained an order of protection against the mother. In January 2022, the day after the newborn's birth, DCFS received a report that the mother gave birth, had other children in DCFS care, and the newborn had become unresponsive after nursing. The newborn was taken to the NICU and placed on a ventilator. DCFS took protective custody of the newborn. The investigation was later unfounded for death by neglect and substantial risk of physical injury/ environment injurious to health and welfare by neglect.

Child No. 55	**DOB: 07/2021**	**DOD: unknown**	**Undetermined**
Age at death:	About 6 months		
Cause of death:	Undetermined		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Infant was reported missing in February 2022. The infant's mother had been arrested for shoplifting, refused to inform police where she lived, and did not inform police her children were home alone. Three days later, the infant's 5-year-old and 7-year-old siblings were found home alone after the

7-year-old called a relative to report they were cold and hungry. The relative went to the home to get the children but could not find the infant. The mother initially told police the infant had never existed, but police found baby items in the home and received information the mother had placed a crib and other items in a dumpster approximately 10 days earlier. The mother later made statements that the infant had died. The infant's body has not been located. The mother was charged with concealing a death and endangering the life of a child. DCFS investigated and indicated the mother for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In May 2021, a relative reported that police had responded to a motel to conduct a well-being check on the infant's then 10-year-old sister. The reporter stated the 10-year-old sister said the mother, who was seven months pregnant, hit her, but she had no visible injuries, and the reporter left the motel after tensions had calmed. The reporter returned to the motel following a second 911 call. The 10-year-old sister was crying; had scratches on her nose, cheek, arms, and hands; and stated her mother hit her and she did not want to be left alone with her mother. The reporter observed a scratch on the mother's lip, and the mother stated they had argued and wrestled. The reporter added concerns about mother's mental health. The CPI responded to the scene and met with a police officer who relayed concerns about the mother's mental state, because the mother appeared confused, suspicious, and uncooperative. The mother stated the 10-year-old did not want to go to the store with the mother and younger siblings so she allowed the 10-year-old to stay at the motel but instructed her to clean while they were gone. Upon returning the mother stated she verbally reprimanded the 10-year-old for not cleaning, and the 10-year-old physically attacked her, so she pushed and restrained the 10-year-old in self-defense. The 10-year-old stated her mother began hitting her when she refused to go to the store, and she hit her mother back, then she called her aunt after the family left for the store. The siblings reported they did not witness their mother hit the older sister and felt safe with their mother. The mother declined intact family services but agreed the 10-year-old should stay with her father, who traveled to the motel to pick her up. The younger sisters remained with the mother. In July 2021, while the previous investigation remained pending, DCFS received a report that the mother gave birth to the infant, and hospital staff were concerned that the mother was exhibiting odd behavior, appeared hostile and paranoid. Hospital staff told the CPI the mother had been appropriate with the infant, and they had no concerns about abuse or neglect. The mother stated she did not like how hospital staff had cared for the infant, so she got irritated and used unkind words. The CPI observed that the mother had a car seat and supplies for the infant. The CPI was subsequently unable to locate the mother. In October 2021, DCFS unfounded the July 2021 investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. The previous investigation remained pending in February 2022 at the time the infant was reported missing. DCFS later indicated the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse; and substantial risk of physical injury/environment injurious to health and welfare by abuse.

Child No. 56	**DOB: 02/2003**	**DOD: 03/2022**	**Undetermined**
Age at death:	19 years		
Cause of death:	Undetermined		
Reason for review:	Deceased was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Nineteen-year-old medically complex teen was found unresponsive in her room at the assisted living facility where she resided. An ambulance transported the teen to the hospital, where she was pronounced deceased. The previous day, she was taken to the emergency room because the facility nurse was unable to remove and change her catheter. The emergency room physician was also unable to change her catheter, provided a catheter bag for her, and discharged her with instructions to follow up with her primary care physician. The morning of her death, she was awake, alert, and had eaten breakfast. The teen was medically complex and required the use of a wheelchair and catheter. She had been diagnosed with paralysis on one side; high blood pressure; neurogenic bowel; obstructive sleep apnea; and

neuromyelitis optica, a central nervous system disease that affects the optic nerves and spinal cord. The coroner documented she had a recent urinary tract infection, recent treatment for streptococcal upper respiratory tract infection, pulmonary edema, sinusoidal congestion of the liver, and obesity. Her toxicology report came back negative for common substances of abuse and showed normal electrolyte levels. DCFS did not investigate the teen's death.

Reason for Review: The teen came into DCFS care in 2019 following an investigation in which her mother was indicated for medical neglect. DCFS initially opened an intact family services case following the investigation, but the mother asked DCFS to take her children less than a month later. The teen spent substantial time in the hospital. In November 2020, the teen was placed at the facility she resided in when she died. The teen's sisters, ages 12 and 14 remained in foster homes at the time of the teen's death.

Child No. 57	**DOB: 03/2019**	**DOD: 03/2022**	**Undetermined**
Age at death:	3 years		
Cause of death:	Cerebral and cerebellar infarcts from dural sinus thrombosis due to dehydration and malnutrition due to an obstructive trichobezoar of the stomach		
Reason for review:	Pending child protection investigation at time of child's death; three unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Three-year-old was found unresponsive by her mother, who called 911. Paramedics performed CPR, administered Narcan because of concerns of drug use in the home, and transported the toddler to the hospital, where she was pronounced deceased. First responders reported the toddler had a bump on her head and appeared severely malnourished. Law enforcement detained three adults in the home. The mother reported the toddler was sick and vomiting in the days prior to her death, but they did not seek medical care. She added the toddler ate her own hair, but they took her for medical care a few months earlier and the doctor did not have concerns about the behavior. Upon autopsy the child was found to have a trichobezoar (concentrated ball of hair) in her stomach that weighed 280 grams. DCFS investigated the toddler's death and indicated her parents for death by neglect.

Reason for Review: The toddler's parents had seven children together, and each had two children from past relationships; the mother maintained primary custody of the maternal half-siblings and the paternal half-siblings lived with the family periodically. The children ranged in age from 5 months to 24 years at the time of the toddler's death. The parents had a history with DCFS between 2009 and 2020, including five indicated investigations, and four prior intact family cases. In mid-October 2021, DCFS received a report that the toddler's then 7-year-old sister was locked out of the home for long periods of time without food or water, the children were often seen outside unattended, and 10 people lived in the one-bedroom home. The reporter also shared the 12-year-old was seen dragging younger siblings by the hair down the street. Police reported they observed the 5-year-old with a scrape on her jawline and marks on her neck. The next day, the CPI went to the home with the assistance of law enforcement. The mother reported she was pregnant, due that month, and had not received any prenatal care. She stated the children did not have a primary care provider, but she had taken them to the county health department within the last year. She denied dragging the children by the hair and denied any of the older children did that to the younger children. The mother denied corporal punishment. The mother reported the home had three bedrooms; one bedroom belonged to the homeowner, one the parents shared with the toddler, and the remaining children slept in the third bedroom. The parents reported they went grocery shopping regularly. The father would not allow the CPI to enter the home but allowed the police officer entry. The police officer reported no environmental concerns. The parents refused to allow the CPI to take photos, but the then 2-year-old toddler, her 5-year-old sister, and 6-year-old sister were noted to be free of observable injuries. Two days later, DCFS received a report that the 8-year-old sister had been taking food from other students and she and the 7-year-old sister requested breakfast because they had not eaten the night before. The report was taken for additional information and the CPI returned to the home. The mother reported she spent the

previous day at the hospital, and the children stayed home from school, but there was plenty of food in the home and the homeowner bought pizza for the children. She reported the children received lunch at school, but not breakfast. The father stated he would ensure the children ate breakfast before school. The parents did not allow the CPI to interview the children separate from the parents but again noted the children appeared free of visible injuries. The verbal children reported having enough to eat and the 12-year-old sister admitted to pulling the other children by the hair. Three days later, the mother gave birth. In mid-November 2021, while the investigation was pending, DCFS received a report that the mother grabbed the 7-year-old by the hair and the father used crack cocaine. The parents again denied the CPI entry and the mother denied the allegations. At the end of November 2021, DCFS received a report that the home had a mouse infestation and left preteen siblings in charge of the younger siblings overnight. The CPI was again denied entry to the home and the mother again denied allegations. In December 2021, DCFS received a report that the parents refused a psychiatric evaluation for a teen sibling. The father again denied the CPI access to the home and the teen denied any psychiatric issues. The father withdrew the children from school and continued refusing to cooperate with DCFS. The CPI contacted the State's Attorney to request a court order for services. The request was pending at the time of the toddler's death.

Child No. 58	**DOB: 11/2021**	**DOD: 04/2022**	**Undetermined**
Age at death:	5 months		
Cause of death:	Sudden unexplained infant death; significant factors of unsafe sleep environment with bedsharing, acute viral bronchiolitis, and laryngomalacia		
Reason for review:	Pending child welfare services referral at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-month-old was found unresponsive, by his paternal grandmother who entered the room to give him medication. He had been sleeping on his back, on a single mattress with his father. The grandmother began CPR and called 911. The infant was pronounced deceased by paramedics who responded to the home. The father reported he cared for the infant full time since February 2022. He stated approximately two weeks before the infant's death, the mother cared for the infant for a few days, and the infant was sick when he was returned to his father's care. Three days later, the father called paramedics because the infant's condition had not improved, and the infant was diagnosed with acute viral bronchiolitis and infantile eczema. He was prescribed a nebulizer, but the family had not begun the treatment because the pharmacy was out of stock. DCFS investigated the infant's death and unfounded his father for death by neglect.

Reason for Review: In November 2021, DCFS received a report with concerns regarding the 18-year-old mother's interaction with her newborn. The infant, who was born prematurely at 34 weeks gestation, was receiving treatment in the NICU, and progressing toward discharge, but the infant's mother refused to change his diaper or provide any care other than feeding him. The reporter stated the mother also had an older child who was in the maternal grandmother's care. The CPI saw the infant and the mother at the hospital that day and implemented a safety plan that the maternal grandmother had to supervise the mother's visits with the infant. The CPI subsequently completed a home safety checklist at the maternal grandmother's home and assessed the home as safe. The next day, the infant was discharged to his maternal grandmother, with the safety plan still in place. The CPI regularly monitored the safety plan. The mother declined to sign temporary guardianship paperwork but agreed to intact family services. It was later determined that the single parent support program and community-based services would be more appropriate for the mother than intact family services. During the investigation, the infant's paternal grandmother contacted the assigned CPI and reported she had been caring for the infant once a week since November 2021, and the infant's father wished to sign voluntary acknowledgement of paternity paperwork. In February 2022, the maternal grandmother was moving out of state, but the mother and children would stay in state with the infant's maternal grandfather. In March 2022, the CPI contacted the

maternal grandmother after attempts to contact the mother were unsuccessful. The maternal grandmother reported the mother and children were doing well and continued to live with the maternal grandfather. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. Eight days before the infant's death, DCFS received a report that the mother left the infant with his father several days earlier, and the father called paramedics because the infant was in respiratory distress, and the hospital was treating the infant but needed permission from his mother, who was his legal guardian. DCFS took the call as a child welfare services referral, and the caseworker attempted to contact the family. The referral remained open when the infant died.

Child No. 59	**DOB: 01/2022**	**DOD: 04/2022**	**Undetermined**
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Full investigation pending		

Narrative: Two-month-old was found unresponsive after co-sleeping with a maternal aunt and twin sister. The aunt called 911 and began CPR. The infant was transported by ambulance to the hospital, where he was pronounced deceased. DCFS investigated the infant's death and indicated the maternal aunt for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In January 2022, upon the birth of the infant and his twin sister, DCFS received three reports on three subsequent days. The reports alleged the mother used cocaine and marijuana during her pregnancy, had been staying in homeless shelters and was in an abusive relationship. The mother reportedly had a mental health diagnosis, and she had a young daughter who lived out of state. The mother and twins tested negative for substances at the time of delivery. The day of the first report, the CPI met with the mother at the hospital, who denied using any drugs during her pregnancy and stated she could stay with the infant's maternal aunt following her release from the hospital. The twins were observed to be healthy, awake, and safe with the mother at the hospital. The family member confirmed the mother could stay with her until she found her own home, and denied the mother used drugs during the pregnancy. In February 2022, DCFS received a report that the mother and twins lacked stable housing and the mother was a sex worker. The CPI spoke with a second maternal aunt, who stated she had taken the mother to a substance use treatment center in November 2021, but the mother left the facility after three days. The CPI made in-person contact with the mother and twins, and noted the twins appeared clean and lacked visible signs of maltreatment but were sleeping in a car seat and did not have cribs. The mother agreed to a safety plan with a third maternal aunt. The maternal aunt reported she had one crib in her home. The CPI provided a portable crib, discussed safe sleep with the aunt, and monitored the safety plan regularly. At the time of the infant's death, the intact family services case had not yet opened, the child protection investigation remained pending, and the infant and his twin remained in the care of the third maternal aunt. DCFS later indicated the mother for substance misuse by neglect, inadequate shelter, and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 60	**DOB: 11/2021**	**DOD: 05/2022**	**Undetermined**
Age at death:	5 months		
Cause of death:	Undetermined		
Reason for review:	Child was a youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-month-old was found unresponsive by his foster father. The infant was transported by ambulance to the hospital, where he was pronounced deceased. He had been born premature, at 33

weeks gestation, was substance-exposed at birth, and his primary care physician reported he had gastroesophageal reflux disease. The foster father reported the pediatrician advised him to place the twins in a reclined position, with their heads up and supported by a pillow due to their acid reflux. He stated he placed the infant, who was still sleeping, in a reclined position on a king-sized pillow on his bed while he fed and changed the twin in an adjacent room. He stated he returned 15 to 30 minutes later and saw the infant had rolled over and was blue. The foster father reported he started CPR, and color seemed to come back to the infant's face, so he attempted to call a friend who was a nurse practitioner. He then called 911 and continued to perform CPR until paramedics arrived. The infant's autopsy noted no evidence of injury or trauma, and the infant was negative for all tested substances and all tested respiratory pathogens. DCFS investigated the infant's death and unfounded his foster father for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In November 2021, DCFS received a report that the mother gave birth to twins prematurely and the mother had five older children in DCFS care. Both the mother and the twins tested positive for cocaine and oxycodone; the mother admitted to using drugs. However, the twins were stable and showed no signs of withdrawal. In December 2021, the twins were discharged from the hospital, taken into protective custody, and placed in a licensed foster home. The foster father attended a training at the hospital before they came into his care. The CPI observed safe sleeping arrangements in the foster home. DCFS indicated the mother for substance misuse by neglect and substantial risk of physical injury/ environment injurious to health and welfare by neglect. The placement worker conducted regular home visits throughout the case. The twins had gained weight at their one-month wellness check. The twins also saw a kidney specialist and began weekly physical therapy following an early intervention evaluation. In January 2022, DCFS received a report that the foster father was carrying both infants in one child carrier. The report was taken as a licensing referral. The placement worker discussed the allegation with the foster father on two occasions and observed two car seats during the conversations. In May 2022, the foster father informed the twins' doctor that they continued spitting up, and the doctor informed him to continue monitoring the behavior, and noted the twins continued to gain weight.

Child No. 61	**DOB: 02/2022**	**DOD: 06/2022**	**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:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Four-month-old was found unresponsive. Her father reported he had fallen asleep with the infant in a full-sized bed for approximately 15 minutes. The infant's maternal grandfather took the infant to a nearby fire station where they unsuccessfully attempted to revive her. She was transported to the hospital, where she was pronounced deceased. The father did not live in the home but helped with the infant. The mother was at work at the time of the incident and the infant's siblings were upstairs. DCFS investigated the infant's death and unfounded the father for death by neglect.

Reason for Review: In mid-February 2022, DCFS received a report that the infant's 10-year-old brother had not been to school since January 2022 because the mother was afraid of COVID. The reporter also stated that when he did come to school he was very behind and wore the same clothes to school every day. In March 2022, the CPI first contacted the family at home. The brother showed off a closet full of clothes and stated he just liked to wear his favorite outfits. The brother reported he bathed every night. The brother and the 5-year-old and 12-year-old siblings reported they felt safe, and the infant was observed to be free of concerns. That month, DCFS unfounded the investigation for inadequate clothing.

PENDING

Autopsies for the following child deaths have not yet been released.

Child No. 62	**DOB: 05/2021**	**DOD: 07/2021**	**Pending**
Age at death:	2 months		
Cause of death:	Autopsy pending		
Reason for review:	Closed intact family services case and unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was found unresponsive in bed with her mother. The grandfather called 911. First responders noted the infant was pale, cold to the touch, and rigor mortis had begun to set in. The mother had a toddler bed and a pack-and-play in her room, but stated the infant was fussy, so she brought the baby into bed with her. The mother admitted to leaving the infant and her 2-year-old half-brother with the maternal grandmother to use methamphetamine several days prior to the infant's death, but stated it was her first use in over a year. The infant's pediatrician reported the mother had a significant history of missing appointments for the infant and her 2-year-old half-brother. Law enforcement noted they found drug paraphernalia in the mother's room. A DCFS investigation of the infant's death remains pending.

Reason for Review: In July 2020, DCFS opened an intact family services case during a pending investigation for reports that the 19-year-old mother was leaving her 1-year-old with the maternal grandparents for days to use drugs with the father who was abusive. Recommended services included substance use treatment, counseling, domestic violence, and parenting education. The mother denied a need for domestic violence services reporting no recent contact with the 1-year-old's father, who was a putative father of the infant, and that she had an order of protection against him. She admitted to using marijuana but denied using methamphetamine. The investigation was unfounded for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. In September 2020, DCFS received a report that the mother left home to use drugs without making a care plan for the then 2-year-old brother; had left drug paraphernalia within reach of the child and had reunited with the father. Law enforcement and the CPI responded to the home. Family members reported the grandmother became angry when the mother wanted to leave with the child; the grandmother then assaulted the mother and police arrested her. The mother, the maternal grandfather, and the maternal aunt stated the mother informed the aunt she was leaving. The CPI noted the mother did not appear to be intoxicated and the child appeared healthy. The mother agreed to a toxicology screening the next day but did not attend the appointment. She completed a screening 10 days later that was positive for marijuana. The intact worker stated the mother smoked marijuana, but they had never seen drug paraphernalia in the home, and there was no evidence the mother or the brother had been around the father. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. The mother continued to cooperate with intact family services, including therapy for the mother and early intervention services for the brother, and the mother attended prenatal appointments. The mother also completed parenting classes. The mother had a crib for the infant, and the CPI discussed safe sleep with the mother. In March 2021, DCFS closed the intact case because the mother had completed services.

Child No. 63	DOB: 01/2021	DOD: 10/2021	Pending
Age at death:	9 months		
Cause of death:	Autopsy pending		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Nine-month-old was pronounced deceased at the hospital. The infant's mother reported that a few hours before his death, the infant was drowsy and congested, so she suctioned him to relieve the congestion and placed him down for a nap. Approximately one hour later, she and the infant left to pick up the infant's 8-year-old brother from school. While riding public transportation, the infant became unresponsive, and a transit security guard called 911. The infant was transported to the hospital, where he was pronounced deceased. A DCFS investigation of the infant's death remains pending.

Reason for Review: In October 2020, DCFS received a report that the infant's then 7-year-old brother was often tardy and absent from school, the mother was using drugs, and the family was living in an abandoned building. The CPI made two attempts to visit the family but did not see them until December 2020. The mother denied the allegations and stated she was kicked out of her mother's home after an altercation and went to live with her paramour, but her children were allowed to stay with the grandmother. She disclosed she was pregnant with the infant. The mother's 7-year-old and 13-year-old sons were interviewed at their maternal grandmother's home. They reported they had lived there for about a year and reported the 7-year-old had a school computer but had trouble logging in for remote learning. Both denied witnessing their mother using drugs or alcohol in the home. The 7-year-old's teacher reported the mother had reached out to the school regarding issues logging in for remote schooling, and he had been logging in on time and was visible on camera for the previous few weeks. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. In August 2021, DCFS received a report that the mother was enrolled in a methadone treatment program but was also believed to be taking illicit substances and breastfeeding the infant; and the mother often had the infant's 8-year-old sibling take care of the infant. The mother was living in a shelter at the time of the report. The CPI communicated with shelter staff two weeks later, but shelter staff reported that the family moved out and they did not know where the family was. The investigation remained pending at the time the child died because the CPI had not located the family. DCFS later indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 64	DOB: 07/2006	DOD: 11/2021	Pending
Age at death:	15 years		
Cause of death:	Autopsy pending		
Reason for review:	Child was a youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old's burned body was found in an alley. The teen had been missing from her placement for two days when the aunt reported the teen left to visit a friend's home and agreed to a curfew, but the teen did not return. That evening, the aunt noticed the teen had left her cellphone behind, which she stated was unusual, and the aunt reported the teen's absence to her placement worker. A police report was filed. The aunt, the placement worker, and the teen's school attempted to locate the teen until DCFS learned of her death. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In September 2021, DCFS opened two investigations following reports that the teen disclosed a physical altercation with her mother and the mother had locked the teen out of the home. School staff stated the teen had reported her mother was physically and verbally abusive. The CPI interviewed the teen's 5-year-old and 9-year-old sisters at school, and both denied witnessing the incident,

and denied any harm or injuries. Five days later, DCFS took protective custody of the teen, though the siblings remained home. No relatives were willing to care for the teen, and she was placed in a shelter. One week later, the teen's placement worker received a report that police were investigating a sexual assault and wanted to schedule a victim sensitive interview with the teen. The teen declined the interview and stated she did not want to get the suspect in trouble. That day, the teen left the shelter and refused to return. She was brought back to the shelter. DCFS indicated the teen's mother for lockout and substantial risk of physical injury/environment injurious to health and welfare by neglect. Shelter staff reported the teen's behavior was out of control and pressured her placement worker to find a new placement for her. In October 2021, the teen was psychiatrically hospitalized following an incident at the shelter. The shelter refused to allow her to return to their facility. The teen was discharged to the care of her godmother. Five days later, the godmother reported the teen was aggressive and refused to follow house rules. She requested another placement but did not demand the teen's removal. Six days later, the godmother reported the teen fled the home, but returned the following morning and was sent to school. The teen was then placed with her maternal aunt. She remained with the maternal aunt for over two weeks and the aunt reported the teen was doing well in her home.

Child No. 65	**DOB: 06/2021**	**DOD: 03/2022**	**Pending**
Age at death:	9 months		
Cause of death:	Autopsy pending		
Reason for review:	Pending child protection investigation at time of child's death; child of a former youth in care		
Action taken:	Investigatory review of records		

Narrative: Nine-month-old medically complex infant was found unresponsive by his mother. The mother reported she had connected the infant to his feeding machine and turned it off when it was done early that morning. She found the infant unresponsive three hours later. At the time of the death, the mother, the infant, and the infant's then 21-month-old sister were living with the mother's former foster parent while waiting for the mother's new apartment to be ready. A DCFS investigation of the infant's death remains pending.

Reason for Review: At the time of the infant's birth, his mother was a youth in care who resided in a transitional living program, and she was parenting the infant's then 11-month-old sister. Her caseworker noted she re-enrolled in school, participated in some services, and kept up with the sister's appointments. In June 2021, she gave birth to the infant and graduated high school. The infant was born with medical complications and remained in the NICU for months following his birth. That fall, the mother found employment and moved into the home of the infant's paternal grandmother. The infant was discharged to his mother's care. In January 2022, the mother emancipated from DCFS. At that time, she was employed, cared for the infant and his sister, and worked with a housing advocate to locate her own apartment. That month, DCFS received a report that the infant had been diagnosed failure to thrive. The infant had a genetic condition that resulted in a small jaw and difficulty eating by mouth and was fed exclusively via g-tube. Hospital staff informed the CPI the infant had gained weight since admission to the hospital, was diagnosed with non-organic failure to thrive, and was recommended for weekly weight checks. Hospital staff added the infant was ready for discharge, but they had been unable to reach his mother and she had not come to the hospital in a few days. The next day, the CPI met with the mother and the infant's then 19-month-old sister at home. The mother stated she followed hospital recommendations for the infant's feeding and demonstrated setting up his feeding machine. The mother stated the infant's paternal grandmother also cared for the infant. The paternal grandmother reported she did not know how to set up the feeding machine, and the infant's mother or father set up the machine for her when she cared for the infant. In February 2022, medical staff reported the mother had been bringing the infant for his appointments and he had been gaining weight. Two weeks before the infant's death, the infant's paternal grandmother reported the mother left home with the infant several days earlier, following a verbal

altercation. The investigation remained pending at the time of the infant's death. DCFS later indicated the parents for failure to thrive to the infant.

Child No. 66	**DOB: 04/2019**	**DOD: 06/2022**	**Pending**
Age at death:	3 years		
Cause of death:	Autopsy pending		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Three-year-old was brought to the emergency room unresponsive where she was pronounced deceased. Medical staff stated the toddler was severely dehydrated, appeared malnourished, was the size of an 18-month-old child, and lacked muscle tone. The father denied the toddler had any pre-existing medical conditions. He reported the family had COVID two weeks earlier, and the toddler did not get better. The parents have been arrested for child endangerment. DCFS investigated the death and indicated the parents for death by abuse and death by neglect. DCFS also indicated the parents for internal injuries by abuse and by neglect; cuts, bruises, welts, abrasions, and oral injuries by abuse and by neglect; malnutrition; and substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect.

Reason for Review: Prior to 2015, the parents' older children were removed from their care and parental rights were terminated. The parents retained custody of their children born after 2015. The parents had three years free of involvement with DCFS. In August 2021, DCFS received a report that the toddler's then 1-year-old sister, who was medically complex and had been hospitalized since her birth, was nearly ready for discharge, but the parents were uncooperative with discharge planning and visited the sister infrequently. The sister had been born at 29 weeks' gestation, displayed minimal brain function, had seizures, and required a trach and g-tube. The CPI met with the family at home and documented observing three of the toddler's siblings. The parents stated they attended regular training for the sister's care but were unable to attend more than once per week due to financial and transportation constraints. Through the investigation, hospital staff reported they felt the parents had become more engaged since DCFS became involved. Medical staff later reported the sister would most likely remain on a ventilator, and the plan was to have nurses care for the sister in the home after discharge. Hospital staff reported the parents had completed their training, but the sister remained in the hospital and did not have a discharge date. In December 2021, the mother gave birth to another child. That month, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect.

ACCIDENT

Child No. 67	DOB: 06/2021	DOD: 07/2021	Accident
Age at death:	2 weeks		
Cause of death:	Complications of maternal trauma		
Reason for review:	Open placement case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-week-old died at the hospital in the NICU. The mother had been struck by a motor vehicle while crossing the street, when she was 39 weeks pregnant. The baby was born that day via emergency c-section. He did not have a pulse for the first 13 minutes of his life; medical staff resuscitated the newborn and placed him on life support. He was transported to another hospital for a higher level of care. He later met criteria for brain death and was removed from life support. DCFS investigated the newborn's death and unfounded the mother for death by abuse.

Reason for Review: At the time of the baby's death, his mother had an open placement case for a 9-year-old sibling who had come into care in 2017. For almost two years, the caseworker recorded no contact with the mother despite numerous attempts and diligent searches. In April 2021, DCFS received a report that the mother was pregnant, and the reporter was concerned about her ability to care for the baby. DCFS did not take the report for investigation as the baby was not yet born but provided the information to the caseworker. In May 2021, the mother contacted the caseworker to inform her of her pregnancy and of her plan to give her sister guardianship of the baby. She also requested the sibling be placed with her sister if possible. The caseworker requested the mother attend a child and family team meeting to discuss the plan, but the mother did not attend. The mother had no further contact before the baby's death. DCFS received a report the day after the birth because the newborn required a transfer to another hospital for a higher level of medical care and the mother was in critical condition and unable to consent. DCFS identified the maternal grandmother as a surrogate decision maker.

Child No. 68	DOB: 04/2018	DOD: 07/2021	Accident
Age at death:	3 years		
Cause of death:	Drowning in swimming pool		
Reason for review:	Two pending child protection investigations at time of child's death; one indicated and two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old was found face down in the pool by his 16-year-old aunt, who jumped into the pool to pull him out and then called 911. The toddler's mother had left the toddler in the care of his 16-year-old aunt while she ran errands and had been out of the home for approximately 35-40 minutes. DCFS investigated the toddler's death and indicated both the mother and 16-year-old aunt for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect because this was the second incident in which the mother had left the toddler with the aunt, and the aunt did not supervise.

Reason for Review: The mother and her children lived with an adult maternal aunt and her infant child, and a teenage maternal aunt, who was in the guardianship of the adult aunt. In August 2020, DCFS opened an investigation against the adult aunt following a report that she allowed her then paramour, who was using cocaine, marijuana, and alcohol and had a history of physically abusing the aunt, back into the home. Everyone in the home denied the paramour lived there. The aunt stated her paramour had come to the home intoxicated and battered her. DCFS indicated the investigation against the aunt for substantial risk of physical injury/environment injurious to health and welfare by neglect. In October 2020, 10 days

after the previous investigation closed, DCFS opened an investigation against the adult aunt following a report that the home was full of garbage and dog urine, and the children were running around unclothed. The reporter called back later that day, wanting to recant the report. The CPI visited the family at their home and observed it to be clean and appropriate, and the children appeared safe. DCFS unfounded the investigation for environmental neglect. In March 2021, DCFS opened an investigation against the toddler's mother after police found the then 2-year-old toddler and his younger brother walking around the neighborhood unsupervised. When the police found the home, the adult aunt and the mother's paramour were home, but the aunt was asleep, and the mother's paramour stated he was downstairs doing laundry. The paramour stated he did not know the children could get over the safety gate and unlock the front door. He reported they installed a safety lock on the front door after the incident. The mother was at work at the time of the incident and confirmed the paramour was supposed to be watching the children. The mother and her paramour separated during the investigation and DCFS unfounded the investigation against the mother for inadequate supervision and inadequate clothing. In May 2021, DCFS opened an investigation against the adult aunt after the then 15-year-old aunt admitted to using medication for self-harm. The teenage aunt received mental health services. DCFS attempted to screen the case into court, but the State's Attorney declined to file a petition. The investigation was pending at the time of the death but was later unfounded. Three weeks before the death, DCFS opened an investigation against the teenage aunt after police found the toddler walking down the street alone, without shoes or pants. The investigation was pending at the time the toddler died. The investigation was later unfounded against the teenage aunt. Family members confirmed the teenage aunt was supposed to be watching the children, and the teenage aunt stated they had all been watching television, but she went to her room, then found the toddler was missing when she returned to the living room a few minutes later.

Child No. 69	**DOB: 03/2021**	**DOD: 08/2021**	**Accident**
Age at death:	4 months		
Cause of death:	Blunt force trauma to the body		
Reason for review:	Siblings returned home and unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old was a passenger in his father's vehicle, along with his mother and 4-year-old brother, while the father was fleeing from police at high speed and lost control of the vehicle. The vehicle crashed into a tree and a vacant house, and the infant and his mother were killed. The infant's 4-year-old brother was treated for minor injuries at the hospital and survived. The father fled the site of the accident on foot. There are criminal charges pending against the father. DCFS investigated the infant's death and indicated the father for death by abuse and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In July 2019, DCFS took protective custody of the infant's then 5-month-old, 1-year-old, and 2-year-old siblings. In September 2020, DCFS received a report that the infant's then 1-year-old, 2-year-old, and 3-year-old siblings, who were placed with their maternal aunt, were living with their mother and maternal grandmother. The CPI observed the children in their mother and grandmother's home on an unauthorized overnight visit. DCFS removed the children from the maternal aunt's home and placed them with their paternal grandmother. In November 2020, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect. In March 2021, DCFS received a report that the mother gave birth to the infant, and the staff had concerns because of her having four other children in the custody of DCFS. The family's caseworker reported the mother had completed parenting classes, was working toward reunification, and the caseworker had no concerns about the infant's safety in the mother's care. The mother's home was assessed to be safe, and the infant was discharged to her custody. That month, the mother began unsupervised visits with her other children. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health

and welfare by neglect. One week before the infant's death, the court returned the children to their mother's care, with the stipulation that the father was not to have contact with the children because he had not cooperated with DCFS or completed any recommended services.

Child No. 70	**DOB: 03/2020**	**DOD: 08/2021**	**Accident**
Age at death:	16 months		
Cause of death:	Asphyxia due to drowning		
Reason for review:	Two indicated child protection investigations and closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-month-old was reported missing from her home around 10:30pm. Her mother had last seen her approximately 15 minutes before she called 911 when she could not find her inside the home. The toddler's 5-year-old sister stated she saw the toddler go out the front screen door, which was observed to be old, with a latch in poor condition. Multiple law enforcement and fire department agencies searched for the toddler overnight. Early in the morning, her body was found in a nearby pond, and she was pronounced deceased at the scene. DCFS investigated the toddler's death and indicated her mother for death by neglect and inadequate supervision because the family knew the door was broken, and the toddler had left the home in a similar fashion two days earlier.

Reason for Review: In June 2020, DCFS received a report about concerns of domestic violence, drug use and mental health issues. Approximately one week later, DCFS received a subsequent call from the reporter, who stated they had seen a photo of the mother holding a methamphetamine pipe. The parents did not live together, and the father did not cooperate with the investigation. The mother denied a current relationship with the father but did allow him access to the children. She admitted to using marijuana but denied methamphetamine use and tested negative for methamphetamine on a toxicology screening. The CPI did not observe any drugs or drug paraphernalia in the home. Law enforcement documented multiple dispatches to the home in the months before the investigation due to domestic incidents between the parents. The mother agreed to intact family services. In August 2020, DCFS opened an intact family case and indicated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect to the toddler and her 3-year-old sibling. The intact case listed the father as a member of the case, but he did not engage with services, did not live in the home, and there was an active order of protection in place for the duration of the case. The mother reported a history of using methamphetamine and cocaine. She submitted to random toxicology screenings, all of which were negative. She also completed parenting classes, participated in domestic violence counseling, followed safe sleep practices, and the children received early intervention services. In December 2020, while the intact case was open, DCFS received a report that the then 8-month-old toddler was diagnosed with a nondisplaced linear skull fracture and hematoma. The mother had brought her to a local emergency room due to fever and swelling to the right side of her head and she was released home after an x-ray showed no injury. The next day, the mother brought her to a children's hospital after the swelling continued, where a CT scan showed the injury. The mother initially provided no explanation for the injury but later stated the toddler hit her head on the faucet during a bath, her sibling struck her with a toy, and the toddler fell off a bed. The infant's grandfather stated he witnessed the first incident, and the grandmother witnessed the second and third; she stated the toddler slept in a twin bed for naps and had once rolled off the bed, onto the hardwood floor. DCFS did not interview the father, and he had not seen the children since October 2020. DCFS indicated the mother for head injuries by neglect and inadequate supervision. In March 2021, DCFS closed the intact case after the mother successfully completed services.

Child No. 71	DOB: 05/2021	DOD: 08/2021	Accident
Age at death:	2 months		
Cause of death:	Probable suffocation		
Reason for review:	Open intact family services case at time of child's death; one indicated and two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was found unresponsive after co-sleeping in an adult bed, with her parents, in a relative's home. The family called 911 but drove to the hospital before emergency responders arrived. The infant was pronounced deceased at the hospital. DCFS investigated the infant's death and indicated the parents for death by neglect. DCFS took protective custody of the infant's siblings the day of her death.

Reason for Review: In January 2021, DCFS opened an investigation after police found the infant's 9-year-old and 8-year-old half-siblings home alone. The 9-year-old sister told police their mother was at work, and they had no way of contacting her. The 8-year-old brother stated their mother and the infant's father often left them home alone and he would call 911 from his tablet if there were an emergency. The mother arrived approximately five minutes later. Police officers informed the mother that the family could not remain in the residence because there was no running water and other building code violations. The mother's other children were residing with other family members. Later in January 2021, while the investigation was pending, DCFS opened a second investigation after receiving a report that the home was uninhabitable. The CPI attempted a visit to the home that day and observed the home to be empty with a notice to vacate posted in the window. The next day, the CPI spoke to the mother by phone, who reported they were evicted the day before due to the lack of running water and the family was staying with the infant's paternal grandmother. The CPI met with the family at the paternal grandmother's home and told the mother she had submitted a Norman services request to pay the outstanding water bill and offered her intact family services. The CPI assessed the grandmother's home to be safe. In early February, the investigation was unfounded for environmental neglect and an intact family services case was opened. In late February 2021, DCFS unfounded the investigation for inadequate supervision with the rationale that they could call 911 from their tablets and had since moved in with relatives. The family's intact family case included services for securing appropriate housing with operable utilities. The intact worker discussed safe sleeping with the family as the mother admitted to co-sleeping despite DCFS providing the family with a pack-and-play. Throughout the case, the family continued to experience homelessness, living with friends and at hotels, and the school reported attendance issues. The mother refused to go to a shelter because the father could not stay with her, and she withdrew from the Section 8 program. In May 2021, at the time of the infant's birth, her meconium tested positive for cocaine and marijuana, and DCFS opened a new investigation. The mother denied drug use since learning of her pregnancy and tested positive only for marijuana. She was offered substance use and mental health services through her intact case but declined these services. In late July 2021, the mother became unresponsive to calls from the intact worker. The mother told the CPI she declined substance use services because she did not believe her marijuana use was a problem. Four days before the infant's death, DCFS indicated the mother for substance misuse by neglect after the CPI conducted a closing visit with the family. The mother stated she intended to continue with intact family services and found a possible home. The children were observed to be free of visible signs of abuse or neglect.

Child No. 72	DOB: 07/2021	DOD: 08/2021	Accident
Age at death:	3 weeks		
Cause of death:	Sudden unexplained infant death with co-sleeping		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Three-week-old was found unresponsive at approximately 4:00am in her mother's bed, where they had been co-sleeping. The father attempted CPR while the mother called 911. The newborn was pronounced deceased at the hospital. The mother admitted she frequently co-slept with her children despite having a small crib in her room. A toxicology screening was positive for alcohol. DCFS investigated the death and indicated the mother for death by neglect and substantial risk of physical injury/ environment injurious to health and welfare by neglect because she tested positive for alcohol and had been provided information on safe sleep from multiple sources.

Reason for Review: In September 2020, DCFS received reports that the newborn's 15-year-old paternal half-sister presented for treatment at the hospital with a black eye and a head injury that required staples, appeared nervous to answer questions, changed her story regarding how she sustained the injuries, and her parents appeared intoxicated. The CPI made a good faith attempt to see the family that day, then documented no additional activity for two months. In November 2020, the CPI spoke with the half-sister at school, who reported she and her friends found a golf cart while their families were camping and began driving it. She stated she was afraid of getting in trouble for riding the golf cart and tried to get off, but fell, hit her head, and began bleeding. She stated when she told her parents, they did not want to take her to the hospital because they had been drinking, so a friend's mother drove the half-sister and the mother to the hospital, where she received seven staples. The half-sister reported that when she got in trouble, the father would take away her phone and the mother would yell at her. The CPI observed the children were free of outward signs of abuse or neglect and the home was appropriate. In December 2020, DCFS unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse with the rationale that the half-sister was nervous because she did something she knew she was not supposed to do, the parents sought immediate medical attention, and the half-sister had no other injuries.

Child No. 73	DOB: 03/2017	DOD: 09/2021	Accident
Age at death:	4 years		
Cause of death:	Multiple injuries due to pedestrian struck by motor vehicle		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Four-year-old was playing at the school playground when a car veered off the road and struck her. The child was transported by ambulance to the hospital, where she was pronounced deceased. DCFS did not investigate her death for abuse or neglect.

Reason for Review: The child came into care in 2017, shortly after her birth, and the child's older siblings were already in DCFS care at that time. In the year prior to the child's death, the mother had the child's 1-year-old and 2-year-old siblings in her care. DCFS opened and unfounded three investigations of the mother during that time. The younger siblings remained in the mother's care, the mother remained compliant with services, and her home was assessed as safe and appropriate. The mother received weekly unsupervised visits with the children in her home, and the child had sibling visits in her older siblings' foster home. At the time of her death, the child was placed in a licensed foster home.

Child No. 74	DOB: 09/2020	DOD: 09/2021	Accident
Age at death:	12 months		
Cause of death:	Hypoxic ischemic encephalopathy due to drowning		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-month-old died at the hospital, two weeks after she had been found unresponsive in the bathtub by her grandmother, who had been babysitting. The grandmother stated she placed the toddler and her 2-year-old brother in a bath, in water that was deep enough to cover the toddler's legs. She later left the children in the bathtub and went to the kitchen, approximately six feet away, to remove a juice box from the freezer and prepare a bottle for the toddler. The grandmother stated that she no longer heard the children playing, and she found the toddler lying on her back in the bathtub with her eyes closed. The grandmother attempted the Heimlich maneuver, then attempted to blow into her nose because she could not tell if the toddler was breathing, then she called 911 and began chest compressions at the instruction of the 911 dispatcher. The toddler was placed on life support at the hospital and medical providers pronounced her brain dead. The toddler was removed from life support and died. DCFS investigated the toddler's death and indicated her grandmother for death by neglect and inadequate supervision to the toddler's 2-year-old brother.

Reason for Review: In September 2020, DCFS opened an investigation after law enforcement arrested the toddler's father following a domestic violence incident in the family's home while the children were present. The parents declined intact family services. In November 2020, at the close of the investigation, the parents no longer lived together. DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect based on law enforcement confirmation of the incident.

Child No. 75	DOB: 05/2019	DOD: 09/2021	Accident
Age at death:	2 years		
Cause of death:	Drowning		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Two-year-old was found at the bottom of a neighbor's pool. Multiple family members had been at the family home celebrating a birthday, and the mother announced she had a headache and went inside to rest. Family members later realized the toddler was missing, so they began searching for her and called police. CPR was attempted after the toddler was pulled out of the pool, but they were unable to resuscitate her, and she was taken to the hospital, where she was pronounced deceased. DCFS investigated the toddler's death and unfounded the mother for death by neglect.

Reason for Review: Three weeks before the toddler's death, DCFS received a report that the mother left for work with a friend and the father followed them in his car, began hitting the vehicle in an attempt to break the window, threatened to kill the mother, then left with the toddler. That day, the CPI made a good faith attempt to see the family at home. There were no additional investigative tasks documented in the case before the toddler's death. DCFS later indicated the father for substantial risk of physical injury/ environment injurious to health and welfare by neglect because he knowingly brought the toddler with him and got into an altercation.

Child No. 76	DOB: 10/2008	DOD: 09/2021	Accident
Age at death:	12 years		
Cause of death:	Craniocerebral blunt trauma		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-year-old was walking with her 11-year-old sibling when a car left the road and struck her. The child was transported to the hospital. Medical staff reported she had sustained traumatic brain injury and had a low likelihood of making a meaningful recovery. Eleven days later, the child was removed from life support and died. DCFS did not investigate the death for abuse or neglect.

Reason for Review: In August 2021, DCFS received a report that the child disclosed that she kicked her great aunt, then her great aunt's friend punched the child in the face, choked her, and threatened to kill her. The child told the reporter she felt safe in the home, except when the great aunt's friend was there. The reporter stated the child's then 11-year-old sister did not corroborate the events. The reporter told the CPI she spoke to the child the day of the incident and did not observe any injuries. The great aunt reported she had chronic obstructive pulmonary disease, and the woman identified as her friend in the report was her home health nurse. She stated she attempted to take the child's phone away to encourage her to get ready for school, and the child kicked her, so the sibling called the home health nurse and the police. The CPI spoke with the sibling at school, whose statement aligned with the great aunt's statement. The child reported she accidentally kicked her great aunt and the home health nurse punched her in the nose approximately an hour before school. Both children reported they felt safe at home and denied their great aunt used corporal punishment. In September 2021, the CPI's supervisor noted the home health nurse was not an eligible perpetrator, as she did not live in the home and was not in a caretaker role. The investigation remained pending at the time of the teen's death. DCFS later unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse.

Child No. 77	DOB: 05/2021	DOD: 09/2021	Accident
Age at death:	4 months		
Cause of death:	Asphyxia due to wedging between a wall and edge of a bed due to co-sleeping in an adult bed with an adult		
Reason for review:	Open intact family services case and pending child protection investigation; two unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation; report to Director June 22, 2022		
	See Death and Serious Injury Investigation 12		

Narrative: Four-month-old was found unresponsive and wedged between an adult-sized mattress and the wall. The mother called 911 and a neighbor attempted CPR until paramedics arrived and transported her to the hospital, where she was pronounced deceased. The mother reported she placed the infant in the bed next to her the night before. The mother admitted to using marijuana and alcohol prior to going to sleep. A toxicology screening was positive for marijuana. A pack-and-play was observed in its carrying case but was missing its mattress. DCFS investigated the infant's death and indicated the mother for death by neglect.

Reason for Review: In June 2021, DCFS received a report that the mother had an open placement case in another state, involving two older siblings in foster care because of mother's history of substance use and mental health issues. She was non-cooperative with services and she fled to Illinois where she gave birth to the infant. The mother refused to give the other state's child protective services access to the infant. The maternal grandfather, who lived in Illinois, reported the mother came to Illinois in April and moved into a shelter. Shelter staff reported the mother had been with them for approximately two weeks and she was cooperating with their program. The mother reported she failed to complete services in the other state because of lack of transportation. She denied she was diagnosed with any mental health conditions. She reported she smoked marijuana which must have been laced with cocaine. She reported she was on

probation in the other state and her probation officer did not know she had moved to Illinois. The mother agreed to intact family services. The CPI assessed the infant as safe. DCFS opened an intact family services case and unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. Recommended services included mental health and substance abuse assessments, random toxicology screenings and domestic violence classes. In July 2021, the intact worker arrived at the shelter for a scheduled visit and staff reported the mother and infant left a few days earlier. The intact worker found the infant in the care of his maternal grandfather. He disclosed that the mother was arrested for a domestic violence incident, and he picked the infant up. DCFS opened a second investigation. The grandfather expressed willingness to care for the infant and the infant was assessed safe in his home. The next day, the maternal grandfather called the CPI to request assistance and stated the mother had been released from jail and was demanding the infant be returned to her care. The CPI directed the maternal grandfather to call police and met them at the home. The mother's toxicology was negative for all substances but agreed to leave the baby with the grandfather. However, four days later, the grandfather told the intact worker he returned the infant to her mother's care because he could no longer care for the baby without financial assistance. The mother was living in a motel at the time. The intact worker offered to provide a pack-and-play, which the mother declined, and the intact worker discussed safe sleep. The mother denied allowing the infant to sleep in bed with her. Two days later, the intact worker delivered the infant's bassinette from the grandfather's house, and the mother reported she did not need anything else. An hour later, the out-of-state placement worker notified the intact worker that the mother was seen giving the infant water during a video call with the older children, and the mother stated she had run out of formula. DCFS opened a third investigation. The intact worker reported the mother received WIC benefits but had not attended her appointments. The CPI provided formula, distilled water, diapers, and clothing. In August 2021, the mother moved out of the motel, into a shelter, but was evicted from that shelter and moved into another shelter. The intact worker reported the mother was not participating in services. The intact worker was directed to staff the mother's case with the State's Attorney due to her lack of compliance. The intact worker made repeated efforts to contact the mother, but she could not be located. Nine days before the infant's death, DCFS unfounded the third investigation for inadequate food; the second investigation remained pending. Two days later, the mother completed a toxicology screening that was positive for marijuana. In the week before the infant's death, the intact worker documented ongoing attempts to contact the mother and re-engage her in services but did not receive a reply. Two days before the death, the mother informed the intact worker she was out of town for a funeral but would not disclose where she was residing. DCFS later indicated the second investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 78	**DOB: 05/2021**	**DOD: 10/2021**	**Accident**
Age at death:	5 months		
Cause of death:	Asphyxia due to prone sleeping position in soft bedding due to co-sleeping in an adult bed with an adult		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation; report to Director on June 17, 2022 **See Death and Serious Injury Investigation 6** Included in systemic issue report; report to Director June 30, 2022 **See Death and Serious Injury Investigation 13**		

Narrative: Five-month-old was found unresponsive in bed with his mother and 911 was called. He had last been seen alive approximately two hours earlier. The infant had recently been sick with respiratory syncytial virus a week prior to his death. DCFS investigated the infant's death and unfounded the mother for death by neglect, environmental neglect, and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In September 2020, DCFS received a report that the infant's then 6-year-old maternal half-sister disclosed sexual abuse by her mother's paramour, the infant's father. The next day, the CPI made a good faith attempt to see the child and met with the children's maternal great-grandmother, who reported the mother and her three children, then 3 through 6 years old, had moved in with her a few days earlier, after the incident with the paramour. The maternal great-grandmother reported the child disclosed sexual abuse to her and the mother had filed for an order of protection, but the paramour had not yet been served. In November 2020, the CPI met with the family at their home and interviewed the child in the presence of her mother, and the child denied the abuse and reported she made it up. The children were noted to be free of visible signs of abuse or neglect. In February 2021, the mother reported they were still living with the great grandmother, and she had not kept the order of protection, because she did not feel it was still necessary. The CPI interviewed the paramour, who denied the allegations. That month, DCFS unfounded the investigation for sexual penetration.

Child No. 79	**DOB: 12/2001**	**DOD: 11/2021**	**Accident**
Age at death:	19 years		
Cause of death:	Combined fentanyl and despropionyl fentanyl (4-ANPP) toxicity		
Reason for review:	Deceased was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Nineteen-year-old became unresponsive after eating candy at the home of her foster mother's relative, initially thought to be because of a diabetic coma. The youth was rushed to the hospital, where she was later pronounced deceased. An autopsy determined she died from toxic levels of fentanyl. The youth's placement worker documented she had been inconsistent with medical treatment related to her diabetes and mental health. She was known to use marijuana, but no other substances were reported. DCFS did not investigate the youth's death.

Reason for Review: The youth came into DCFS care in 2018, during an investigation in which her father was indicated for lock out after the youth ran away from home. At the time of her death, she was placed with a fictive kin caregiver. She had an almost 2-year-old child, and her foster mother was reported to be a good support to her and her child.

Child No. 80	**DOB: 08/2021**	**DOD: 11/2021**	**Accident**
Age at death:	2 months		
Cause of death:	Hypoxic ischemic encephalopathy due to positional asphyxia due to prone position within bassinette, with soft objects		
Reason for review:	Closed intact family services case, one indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was having difficulty breathing, so his father called 911. Medical staff reported the infant was stabilized at the hospital but had a brain bleed and was unresponsive. He later was pronounced brain dead. Five days after hospital admission, he was removed from life support and died. The infant had been born premature, at 33 weeks gestation, and had been treated in the NICU. At the time of the 911 call, the infant and his 1-year-old brother were in the care of their father while their mother was working. At the hospital, the infant also showed signs of severe dehydration. The infant's crib was observed to have a full-size pillow, and the parents reported they placed the infant to sleep on the pillow that day because he preferred sleeping on his stomach on soft surfaces. Service providers who worked with the family reported they had spoken with the mother at length about safe sleep practices. The autopsy revealed the infant died of suffocation. DCFS investigated the infant's death and indicated the father for death by neglect, indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect, and indicated the parents for inadequate supervision.

Reason for Review: In November 2020, DCFS received a report that the mother did not bring the infant's then 7-month-old brother to an orthopedic specialist and physical therapist for his legs being bowed, often forgot to give him his medication, and failed to take him to appointments. The brother had been diagnosed with failure to thrive at 6 weeks old and had been hospitalized. Medical staff reported to the CPI that the appointment for his legs was delayed due to the COVID pandemic, but the brother had been gaining weight, and they did not believe the mother was medically neglecting the brother. In January 2021, DCFS unfounded the investigation for medical neglect. Four days after the investigation closed, DCFS received a report that police responded to a domestic disturbance at the father's home, in the presence of the brother. Police made no arrests but noted the mother had a red area on her cheek. The father refused to meet with the CPI or provide a statement to DCFS. The mother disclosed the father had previously been physically violent. The mother disclosed that she was pregnant and agreed to participate in intact family services. Four days into the investigation, DCFS received a report that the infant's then 8-year-old maternal half-brother had been caring for the 8-month-old brother and 6-year-old maternal half-sister, who had a burn on her hand, because the infant's father no longer watched them. The CPI saw the children that day and verified they were safe and supervised. The mother reported that when she worked, the 8-year-old went to his father's home and the infant's maternal aunt watched the 8-month-old and 6-year-old. The CPI noted the 6-year-old's finger did not appear burned. DCFS received a similar report one week later. The infant's maternal aunt confirmed she watched the children while the mother worked. At the end of January 2021, DCFS opened an intact family case and identified service needs for counseling, housing, and possibly childcare. In March 2021, DCFS indicated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect because of the police report and the mother's statement. DCFS unfounded the mother for burns by neglect, inadequate supervision, and substantial risk of physical injury/environment injurious. The mother did not comply with services during the intact case and in May 2021, the mother stated she wished to withdraw from intact services. The intact team requested court ordered supervision, but the State's Attorney's Office declined to file a petition, citing that the mother had been unfounded in the previous investigation. In July 2021, the intact worker learned the mother and 8-month-old brother were staying with the infant's father, and the infant's maternal siblings were with their father out of state. The intact worker informed the mother she would close the intact case but needed to see the children before doing so. The mother stated the children were with their fathers, who would refuse to cooperate with the intact worker, so the intact worker contacted law enforcement to request wellness checks on the children. Law enforcement reported there had been no domestic disputes at the address of the infant's father since January 2021. The mother agreed to bring the children for an in-person meeting with the intact worker, and they were noted to appear healthy. In July 2021, the intact case was closed, citing involuntary withdrawal.

Child No. 81	**DOB: 12/2020**	**DOD: 11/2021**	**Accident**
Age at death:	11 months		
Cause of death:	Thermal injuries		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eleven-month-old died at the hospital with partial and full thickness burns to 90% of his body. The infant, his mother, and her paramour were in a garage with a wood-burning stove, and the infant had been placed in front of the stove. There was an explosion, and the infant was engulfed in flames. The infant was transported to the hospital, where he died later that day. Hospital staff noted the mother's speech was slurred and she appeared intoxicated. She tested positive for methamphetamine. The paramour admitted he and the mother had used methamphetamine that morning. The mother had partial thickness burns to her hands, arms, and legs. The infant's siblings were not in the mother's care at the time of the incident. DCFS investigated the infant's death and indicated the mother for death by neglect and burns by neglect.

Reason for Review: In April 2021, DCFS received a report that the parents used methamphetamine around their children. That day, police completed a wellbeing check and reported no concerns. The following day, the father admitted to the CPI that he used methamphetamine the weekend before and attempted to use someone else's urine for a toxicology screening. The father reported the infant's 10-year-old paternal half-brother and 11-year-old brother attended school during the day and the infant's maternal aunt watched the infant while the parents worked. The mother reported she took the children out of state that weekend and the father was alone when he used methamphetamine. The CPI assessed the children as safe at the home. The father signed short-term guardianship papers for the infant's paternal half-brother, and the mother stated she planned to obtain an attorney to get full guardianship. The father was incarcerated for violating the terms of his probation. The mother reported she wished to move out of state, where she had more familial support. In June 2021, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect because the father relapsed when the children were out of state, he was sent to prison, and there were no concerns about the mother's ability to care for the children. In August 2021, DCFS received a report that the mother was using methamphetamine and had left the children with relatives. During the investigation, the reporter stated she did not have evidence the mother was using drugs, as other people had told her. The mother stated she left the infant with a friend for one night, then she received a call from the paternal grandmother, who stated she planned to call DCFS. The mother's toxicology tested negative for all substances. In October 2021, DCFS unfounded the investigation for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 82	**DOB: 05/2020**	**DOD: 11/2021**	**Accident**
Age at death:	18 months		
Cause of death:	Blunt force injuries of the head due to a fall from the stairs		
Reason for review:	Child was a youth in care; one indicated and one unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eighteen-month-old fell down the stairs while in the care of a babysitter, her foster mother's adult daughter, while her foster mother moved. The babysitter reported the toddler fell down the stairs after she was startled, cried briefly, then became unconscious. The babysitter took the toddler to the foster mother's home across the street and the family called 911. The toddler was transported to the hospital by ambulance, where she was pronounced deceased. DCFS investigated the toddler's death and indicated the babysitter for death by neglect, head injuries by neglect, inadequate supervision, and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: At the time of the toddler's birth, her then 1-year-old and 3-year-old sisters had been in DCFS care since March 2020 after their mother had an indicated child protection investigation. The toddler came into care shortly after birth. After having surgery for a g-tube placement she was placed with her godmother. In November 2020, DCFS received a report that the toddler's then 4-year-old sister was displaying sexualized behavior. In a forensic interview, the 4-year-old disclosed sexual molestation. DCFS indicated an unknown perpetrator for sexual molestation. In February 2021, DCFS received a report that the toddler's then 2-year-old and 3-year-old sisters accessed a bag of multivitamins while their foster mother was in the shower. The foster mother believed the 2-year-old may have ingested a few vitamins, so she took her to the emergency room where she was examined and discharged. DCFS unfounded the investigation for poison and inadequate supervision with the rationale that the sisters' pediatrician stated the foster mother acted appropriately and locked all medications and kept them out of reach of the sisters. The children's caseworker made regular visits to their foster homes and their mother participated in parenting classes and therapy. In June 2021, the toddler's case was transferred to a private agency for specialized foster care due to her ongoing medical needs, and her caseworker advised her foster mother on steps she needed to take to become a licensed foster parent.

Child No. 83	DOB: 10/2015	DOD: 11/2021	Accident
Age at death:	6 years		
Cause of death:	Multi-organ failure due to hypoxic-ischemic encephalopathy due to drowning		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-year-old medically complex child brought to the hospital after being found unresponsive and died days later. In 2019, the child experienced a near-drowning incident in a pond near her home. She never fully recovered and was intermittently hospitalized for the following two years. DCFS indicated her father for inadequate supervision after the incident. The child's medical history included congenital conditions and complications from her near drowning. She had been diagnosed with cerebral palsy, quadriplegia, neurogenic bladder, dysautonomia, recurrent UTI, dystonia, acute respiratory failure, and hypoxic encephalopathy. DCFS investigated her death and indicated her father for death by neglect because her death was ruled related to her near drowning.

Reason for Review: Following the near drowning incident in 2019, the child and her two foster siblings were placed with the paternal grandparents. In November 2020, DCFS received a report that the 1-year-old foster sister left the house and was running down the street, and the 3-year-old foster brother came close to touching a hot barbecue smoker while at a family gathering. The CPI observed the children to be clean, dressed appropriately, and free of marks or bruises. The paternal grandparents stated the foster sister left the play area but did not get far away and she was brought back quickly, and the foster brother did reach toward the barbecue smoker but was stopped before he touched it. The investigation was unfounded. In January 2021, the child's foster siblings were returned to the mother's care. In February 2021, the family's caseworker reported the foster siblings were doing well since their return to the mother's home and the father was still only allowed supervised visits.

Child No. 84	DOB: 11/2007	DOD: 11/2021	Accident
Age at death:	14 years		
Cause of death:	Multiple injuries due to motor vehicle striking pedestrian		
Reason for review:	Split custody		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old was crossing the street with a 12-year-old friend when he and his friend were struck by a motor vehicle. The teen died at the scene and his friend was taken to the ICU in critical condition. The driver of the vehicle was arrested on DUI charges. DCFS did not investigate the teen's death.

Reason for Review: The teen had lived with his grandmother since his mother's death in 2009. In 2019, DCFS took protective custody of the teen's then 16-year-old brother on a dependency petition. The teen's brother experienced multiple placements since that time, including relative homes, group homes, incarcerations, and inpatient hospital stays. In May 2021, the family's case was closed because the brother's goal was set to independence. At the time of the teen's death, the brother resided in a transitional living facility.

Child No. 85	DOB: 07/2021	DOD: 12/2021	Accident
Age at death:	4 months		
Cause of death:	Asphyxia due to unsafe sleeping environment		
Reason for review:	Child of a youth in care		
Action taken:	Investigatory review of records		

Narrative: Four-month-old was found unresponsive. The infant's mother reported they drove the infant to the fire station, and he had no pulse on arrival, so CPR was started. The infant was transported by ambulance to the hospital, where he was pronounced deceased. The mother reported she fed him

approximately one hour earlier and fell asleep on the couch with him in her arms. The mother is a youth in care and was placed with the infant's paternal grandmother, but the family was on an overnight visit in the home of the infant's maternal grandmother at the time of the infant's death. DCFS indicated the infant's mother for death by neglect.

Reason for Review: The infant's mother came into DCFS care in 2019, when the infant's maternal grandmother was in an altercation with a relative and stabbed the relative several times. The maternal grandmother was reported to be non-compliant with recommended services. In 2020, the mother was placed with the infant's paternal grandmother, a fictive kin placement. The mother was parenting the infant's then 1-year-old sibling and was referred to the Teen Parent Services Network for therapy, parent training/coaching, financial literacy training, and employment/job training services. The mother communicated regularly with the caseworker through visits and video chats. The home was observed to be clean and free of safety hazards, the infant and his sibling had their own separate sleeping arrangements, and none of the children had ever been observed to have marks or bruises. The mother was cooperative and compliant with all services recommended for the children. There is no record the infant's father was involved in services prior to the infant's death.

Child No. 86	**DOB: 07/2021**	**DOD: 12/2021**	**Accident**
Age at death:	5 months		
Cause of death:	Overlay due to unsafe sleep environment		
Reason for review:	Pending child protection investigation and split custody at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Five-month-old was found unresponsive on a couch. His mother called 911 and began CPR. The infant was transported by ambulance to the hospital, where he was pronounced deceased. The infant, his mother, and his 2-year-old brother, fell asleep on a couch at the maternal grandmother's home while the mother was waiting for transportation to the shelter where she was staying. When the mother awoke, she found the 2-year-old brother lying on top of the infant. The maternal grandmother stated she had gone to sleep because she did not feel well, and the infant's maternal aunt was also in the home and was supposed to watch the infant's siblings. The DCFS investigation into the infant's death remains pending. DCFS also opened an investigation against the infant's maternal grandmother and unfounded her for inadequate supervision.

Reason for Review: The infant's then 1-year-old and 6-year-old siblings came into DCFS custody in November 2020 and were placed with their maternal grandmother. The family's placement worker completed monthly in-person and virtual visits. The mother visited the children weekly. The 6-year-old sister was referred for screening for a speech delay, and the 1-year-old brother was referred for physical therapy. The mother was referred for parenting classes and individual therapy. In December 2020, the mother reported she was pregnant. The father of the infant and 1-year-old brother initially participated in visits but was not compliant with services. In March 2021, the father ceased communication with the placement worker. In May 2021, the then 7-year-old sister's father had his paternity confirmed and was referred for parenting classes and domestic violence services, but he did not follow through. In July 2021, DCFS received a report of the infant's birth. DCFS opened an investigation to determine whether the infant could remain in his mother's care. The mother was compliant with all services and the siblings' permanency goals had been set to return home. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. The infant was allowed to remain in his mother's care. The placement worker continued regular visits and noted the siblings were doing well. The mother had unsupervised visits and was engaged in services, but the placement worker noted her attendance at parenting classes became inconsistent following the infant's birth. In October 2021, the mother reported to the placement worker that the infant's father assaulted her, and she required medical

care. The father was arrested, and the mother obtained an order of protection. That same day, DCFS received a report that the mother had a sex offender living in her home and that the home was dirty. Thirteen days before the infant's death, the mother told the placement worker that the father broke into her home and set it on fire. She informed the placement worker that she was staying with friends and the maternal grandmother was caring for the infant until she found housing. That day, the CPI went to the maternal grandmother's home and observed the infant and his siblings. The investigation and the siblings' placement cases remained open at the time of the infant's death. DCFS later unfounded the investigation for environmental neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 87	**DOB: 03/2007**	**DOD: 01/2022**	**Accident**
Age at death:	14 years		
Cause of death:	Heroin and fentanyl intoxication		
Reason for review:	Pending child protection investigation at time of child's death; three unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Fourteen-year-old was found unresponsive by her mother around 9:30am. Emergency responders found the teen in her mother's bedroom, wedged between the wall and bed, and noted the home had dirty dishes in the sink, mouse traps, and stagnant water in the bathtub. Three days earlier, the teen had tested positive for COVID. The mother reported she had woken the teen from a nightmare around 4:00am and encouraged her to go back to sleep. DCFS investigated the teen's death and indicated the mother for death by neglect, environmental neglect, and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In June 2021, DCFS received a report that the teen's mother and her paramour used drugs, allowed a 20-year-old neighbor to hit and discipline the children, and the children were malnourished. The mother denied drug use and agreed to obtain an order of protection against her former paramour, who she stated threatened to call DCFS when she ended the relationship. The CPI documented the teen, her 4-year-old sister, and her 7-year-old brother appeared healthy, free of marks or bruises, and denied witnessing their mother use drugs or alcohol. The CPI noted there was adequate food in the home and no concerns about the environment. A neighbor reported no knowledge of drug use in the home and stated the mother was a good parent. The CPI spoke with the mother's former paramour, who recanted his report to the Hotline. In July 2021, while the first investigation was pending, DCFS received a report that the family home was unsanitary, had dead rodents, food left out, and had a foul smell. The next day, the CPI noted the home did not appear as described in the Hotline report and had no observable safety hazards. In August 2021, DCFS received a report that there were bags with a white powdery residue and straws hidden throughout the home, and there were domestic violence incidents in the home, but the children were always outside and did not witness the incidents. The report was taken for additional information on the second investigation. Two days later, law enforcement reported to DCFS that they responded to a report of an altercation between the mother and the former paramour. Law enforcement confirmed the mother obtained an order of protection against the former paramour. That month, DCFS unfounded the first investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. DCFS unfounded the second investigation for inadequate supervision, environmental neglect, and medical neglect as mother had obtained an order of protection and had a negative toxicology screen. In November 2021, DCFS received a report that the teen, who had autism, had been living with her father for four days, he left the teen alone 10 to 12 hours, and did not have appropriate food as the teen had allergies. DCFS opened a third investigation. The father reported he knew of the teen's allergies and provided appropriate food, the teen had a physical exam scheduled for that day, and the teen did not have autism but had ADHD. The teen reported she felt safe with her father but uncomfortable in the home because she had never lived with only him; there was always food for her, her father asked a neighbor to

check on her when she was home alone, and she knew who to call in an emergency. The CPI observed adequate food in the home. The teen's paternal grandmother reported she picked the teen up at school daily and watched her until the father finished work. In December 2021, DCFS unfounded the third investigation for inadequate food and inadequate supervision. Four days after the third investigation opened, DCFS received a report that the teen's mother had been arrested and law enforcement found drug residue in her car. The next day, the CPI found the teen's 5-year-old and 7-year-old siblings home alone. A neighbor reported the children had been told to go to his home after school because the mother had to work, but the children denied being given those instructions. The CPI interviewed the mother later that evening and the mother stated she arranged for the children to go to the neighbor's home after school, and denied the drugs were hers as she had borrowed the car from a friend. The investigation remained pending at the time the teen died. DCFS later unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by neglect.

Child No. 88	**DOB: 11/2021**	**DOD: 01/2022**	**Accident**
Age at death:	8 weeks		
Cause of death:	Asphyxia due to unsafe sleeping environment		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-week-old was found unresponsive by his mother after he had been placed to sleep in an adult bed, between his parents. His mother called 911 while his father began CPR. The infant was transported to the hospital by ambulance, where he was pronounced deceased. The parents reported they placed him in bed instead of in his bassinette because he had been congested and fussy in the days leading up to his death. Medical records noted the parents brought the infant to the emergency room approximately a week before his death for persistent diaper rash, and the treating physician noted the rash was likely caused by poor hygiene. Medical staff also noted the infant was underweight, in the first percentile for his age. DCFS investigated the infant's death and indicated the mother and father for death by neglect.

Reason for Review: Two weeks after the infant's birth, DCFS received a report regarding a domestic violence incident between the parents. The next day, the CPI was unable to gain access to the family's apartment, but spoke to the mother by phone, who stated the infant was sleeping in his crib in a different room when the incident occurred. She and the infant left to stay with family in a neighboring state. Law enforcement in the other state conducted a well-being check and observed the infant had a safe sleeping arrangement and was free of visible signs of abuse or neglect. Five days later, the CPI spoke with the father at the family's home, who stated the mother grabbed a knife and attempted to stab him. The CPI observed the home to be appropriate, with safe sleeping arrangements for the infant, and completed domestic violence and substance abuse assessments with the father. DCFS later indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect after receiving police records that showed a history of domestic violence, the father violated an order of protection, and the mother was hospitalized twice following domestic violence incidents.

Child No. 89	**DOB: 08/2004**	**DOD: 02/2022**	**Accident**
Age at death:	17 years		
Cause of death:	Blunt trauma to the head due to motor vehicle crash		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old sustained fatal injuries while riding as a passenger in a car that struck a tree. Emergency services took the teen to the hospital, where she died of her injuries. DCFS did not investigate the teen's death.

Reason for Review: In March 2021, DCFS received a report that the teen's mother was using cocaine in the presence of the teen. The mother initially agreed to a toxicology screening, but later declined and stated she previously used cocaine and her children were removed from her care, but she completed services and her children were returned to her. She admitted to relapsing and using cocaine a few weeks prior but stated she wanted to maintain sobriety had not used it again. The teen denied her mother used cocaine and reported she did not fear her mother. The school and a collateral contact reported the teen had been doing well recently and her primary care provider had no concerns. Nine days after the Hotline call, DCFS unfounded the investigation at the initial stage for substantial risk of physical injury/environment injurious to health and welfare by neglect because the teen denied her mother used cocaine. Both the teen and her mother declined services.

Child No. 90	**DOB: 12/2021**	**DOD: 02/2022**	**Accident**
Age at death:	2 months		
Cause of death:	Positional asphyxia due to prone sleeping in an unsafe sleep environment		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two month-old was found unresponsive by her mother, who called 911. The mother reported she had been breastfeeding the infant around midnight, fell asleep, and awoke several hours later to find the infant was on her stomach and not breathing. DCFS investigated the infant's death and unfounded the mother for death by neglect.

Reason for Review: In January 2022, DCFS received a report that the infant's 12-year-old brother told classmates he could not play video games because there were cockroaches inside his game console, and the reporter was concerned about the cockroaches around the infant. That day, the CPI met with the family at home. The parents admitted they had seen cockroaches in their home, they had set traps and used bait for the past week, and they cleaned regularly. The CPI observed no insects in the home. The infant and her 21-month-old, 4-year-old, and 12-year-old siblings appeared healthy, clean, and appropriately dressed. The 12-year-old brother stated he had last seen a cockroach the prior week. The 4-year-old brother reported no concerns. Medical staff in the office of the children's primary care provider reported no concerns for abuse or neglect. Eighteen days before the infant's death, the CPI returned to the home and the parents reported the home was consistently treated, and they had not seen any insects. The CPI discussed safe sleep with the mother, and the children again appeared healthy, clean, and free of injuries. The investigation remained pending at the time of the death. DCFS later unfounded the investigation for environmental neglect.

Child No. 91	**DOB: 09/2021**	**DOD: 02/2022**	**Accident**
Age at death:	5 months		
Cause of death:	Asphyxia due to wedging		
Reason for review:	Two pending child protection investigations at time of child's death		
Action taken:	Full investigation pending		

Narrative: Five-month-old was found unresponsive between couch cushions by his mother. His maternal grandfather began CPR and the family called 911. The infant was transported by ambulance to the hospital, where he was pronounced deceased. The mother stated the infant usually slept in his pack-and-play at night, but he had woken up, so she picked him up and they both fell asleep on the couch. She confirmed a CPI had educated her on safe sleep and provided a pack-and-play. DCFS investigated the death and indicated the mother for death by neglect.

Reason for Review: Five days after the infant's birth, DCFS received a report that the mother left the pediatrician's office before tests were completed for the infant, and the mother did not bring the infant for a scheduled appointment. The reporter noted the infant's bilirubin levels were above the 75% range and

could cause developmental delays if left untreated. That day, the CPI met with the mother at home, who reported she had transportation barriers. During the home visit, the mother rescheduled the appointment and confirmed she had transportation. The CPI completed a home safety checklist, found no safety issues, and observed safe sleep arrangements. In January 2022, while the first investigation remained pending, DCFS received a report that the 20-year-old mother, who lived with the infant's maternal grandparents, arrived home intoxicated and initiated a physical altercation with the maternal grandmother while the infant was in the room. Police were called to the home and witnessed the mother grab a phone from the maternal uncle while holding the infant, and the phone hit the infant, causing him to cry. The mother was arrested for domestic battery. The mother told the CPI that she was arguing with the maternal grandmother when the maternal uncle intervened and hit her first. She stated the infant was sleeping during the incident and was not injured, and it was the first time an incident like that had occurred. She denied drinking alcohol but admitted to using marijuana. The maternal grandparents reported they were concerned when the mother returned home because she was not acting like herself, so the maternal grandmother confronted her, the incident escalated, and the maternal grandmother attempted to restrain the mother so she could not hurt anyone. The grandparents reported the infant was sleeping in another room at the time. The maternal uncle reported he had been sleeping during the incident and his girlfriend woke him. He stated he grabbed the mother when the argument turned physical, but the mother kept fighting, and the grandparents also attempted to end the fight. He reported no incidents had occurred before and he did not see the infant during the altercation. While in the home, the CPI did not observe safe sleep arrangements for the infant and was informed the infant slept in bed with his mother. The CPI discussed safe sleep with the family and provided and helped set up a pack-and-play. Both investigations remained pending at the time of the infant's death. DCFS later unfounded the first investigation for medical neglect with the rationale that the mother brought the infant to his rescheduled appointment and his bilirubin levels had reduced. DCFS indicated the second investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse with the rationale that the mother was witnessed acting recklessly.

Child No. 92	**DOB: 06/2004**	**DOD: 03/2022**	**Accident**
Age at death:	17 years		
Cause of death:	Massive internal injuries due to single vehicle accident		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old died in a car accident. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In July 2021, DCFS received a report that the teen and her 16-year-old brother were involved in a physical altercation with their stepfather. The reporter stated the stepfather shoved the teen when she attempted to intercede, and the brother then hit the stepfather and fled the home. All members of the family shared accounts of the incident that concurred with the Hotline report and neither the teen nor her brother were injured. The children were assessed as safe because the brother was identified as the aggressor. The family reported no additional incidents between the stepfather and the children. The family reported the teen's brother continued to have behavioral issues but the parents refused services. The CPI completed a domestic violence screening with the mother and advised the stepfather to complete anger management services. In September 2021, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect.

Child No. 93	DOB: 04/2018	DOD: 03/2022	Accident
Age at death:	3 years		
Cause of death:	Blunt force head trauma due to pedestrian struck by a semi-tractor trailer truck		
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 struck and killed by a semitruck after he left the family's apartment while in his father's care. The mother was not home at the time. The toddler was pronounced deceased at the scene. The father stated he placed the toddler on the floor in the living room, then went into his own bedroom to watch videos using headphones, and he did not hear the toddler leave. Law enforcement reported they found the main door unlocked and the father was in a room with the door mostly closed. He was unaware the toddler was gone. The father reported the toddler had a history of escaping from the home, so they installed a safety knob inside the main front door. The parents also reported the lock on the sliding porch door had been broken since they moved in, so they secured it with a rod, but law enforcement observed the rod was not in place. The father admitted to drinking one to two beers earlier in the afternoon and there were empty beer cans in the room. DCFS investigated the toddler's death and indicated the father for death by neglect.

Reason for Review: In February 2021, law enforcement responded to a report that the family home lacked heat and hot water, the toddler slept in a car seat, and the toddler had not been bathed in a week. Law enforcement stated the home was dirty with trash piled up, the father admitted to putting the toddler to sleep in a car seat and heating the home with an electric heater. The CPI met with the family and observed the home to be warm with running water, but dirty and cluttered with beer cans in the parents' bedroom, and a broken water heater. The parents stated they heated water on the stove to bathe the toddler. The CPI determined the home needed cleaning but was safe. One week later, the CPI observed the home to be cleaner, and the parents were scheduled to receive a new water heater that week. DCFS unfounded the investigation for environmental neglect.

Child No. 94	DOB: 03/2022	DOD: 04/2022	Accident
Age at death:	2 days		
Cause of death:	Complications of prematurity due to placental abruption due to maternal trauma; significant contributing condition of motor vehicle collision		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-day-old died in the hospital where he had been born prematurely, by emergency c-section, at 29 weeks gestation. His mother had been a passenger in a vehicle involved in a police chase and accident. The newborn was treated in the NICU following his birth. His toxicology screening came back positive for barbiturates. DCFS investigated the death and unfounded the mother for death by neglect but indicated her for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In June 2021, DCFS received a report that the mother and her paramour were involved in a domestic dispute during which the paramour struck and beat the mother with a gun, the mother jumped out of a window to escape, and the newborn's then 1-year-old sister and 4-year-old brother were present. The mother and the siblings were examined at a hospital; the siblings were discharged to their maternal grandmother the same day, but the mother remained hospitalized. The 4-year-old brother was observed to have bruising, abrasions, and marks to his face and medical staff reported the 1-year-old did not sustain any injuries. The mother reported she had known the man who beat her for approximately five years and had dated him for a short period of time, but he was not her paramour, and they had no history of domestic violence. She stated she asked the former paramour for a ride to the mall and grocery store. He agreed to take them, then brought them to his house because he stated he did not have his keys. He then struck and dragged the mother into his home, hit and choked the 4-year-old brother, held a gun to

the brother's face, stated he would kill him, and hit the 1-year-old sister in the leg. She stated the incident continued the entire night. She stated the former paramour also attempted to shoot someone outside his home. The mother reported multiple unsuccessful attempts to get help and eventually jumped from an open second floor window, knowing she was unable to take her children with her, but she was able to call 911. Police arrested the former paramour. The mother sustained two broken bones in her pelvis and spinal injuries. In August 2021, DCFS unfounded the investigation for cuts bruises welts abrasions and oral injuries by abuse and substantial risk of physical injury/environment injurious to health and welfare by abuse because the ex-paramour was not an eligible perpetrator, as he was not the children's father, was not the mother's paramour, and was not placed in a caretaking role for the children. The former paramour was found guilty of aggravated battery and sentenced to three years in prison.

Child No. 95	**DOB: 11/2005**	**DOD: 04/2022**	**Accident**
Age at death:	16 years		
Cause of death:	Complications of cocaine and benzodiazepine toxicity		
Reason for review:	Open intact family services case at time of child's death; three unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old was removed from life support after being declared brain dead. He had been found unresponsive nine days earlier. The teen had a history of drug use, prior overdose incidents, and hospitalizations for drug use. DCFS investigated the teen's death and unfounded his mother for death by neglect because the mother attempted to get him help multiple times.

Reason for Review: In the year prior to his death, the teen was on probation, was hospitalized multiple times for drug use and overdose, was enrolled in multiple substance use treatment programs with which he was noncompliant, and police responded to the home multiple times for altercations between the teen and his mother. In April 2021, DCFS received a report that the teen had two emergency room visits and 911 calls related to drug use in the previous 24 hours, the mother was verbally abusive, and the teen sustained a concussion when he intervened in a fight between his mother and maternal grandfather. The mother denied hitting the teen and the teen stated he lied about his mother because he was angry at being hospitalized. One week later, the hospital discharged the teen into a 60-day inpatient substance use treatment program, but he was discharged for noncompliance after 35 days. He participated in a twice-weekly virtual program. In June 2021, DCFS opened an intact family services case. The pattern of drug use, hospitalizations, failed treatment, and altercations with his mother continued. In September 2021, the intact worker staffed the teen's case with DCFS Clinical to pursue additional services and assessments for the teen. In December 2021, DCFS received a report that the teen and his mother had an altercation and she bit him. This was later unfounded after both the teen and his mother denied the allegation. In March 2022, the State's Attorney filed a petition due to the teen's failure to complete services. One week later, the teen tested positive for cocaine and benzodiazepine and was admitted to inpatient substance use treatment. Two days after discharge, his mother confronted the teen after she found pills in his room and an altercation ensued. Police transported the teen to the hospital, and he was medically discharged, but the mother refused to pick him up. DCFS opened an investigation for lock out, but the following day the mother agreed to have the teen discharged to her care and five days later DCFS unfounded the mother. Nine days before the teen's death, the teen had again overdosed and was hospitalized. Hospital staff reported he tested positive for marijuana, benzodiazepines, cocaine, and alcohol and a CT scan showed little brain function. He remained hospitalized until his death.

Child No. 96	DOB: 01/2022	DOD: 04/2022	Accident
Age at death:	3 months		
Cause of death:	Asphyxia due to being found face down in a portable crib		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unresponsive and not breathing by his daycare provider, who called 911. The infant was transported by ambulance to the hospital, where he was pronounced deceased. Paramedics reported the infant had dried blood around his nostrils and in the back of his mouth. The daycare provider reported she put the infant down for a nap approximately two hours before she found him unresponsive. DCFS investigated the infant's death and unfounded the daycare provider for death by abuse and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In November 2021, DCFS received a report that the infant's 10-year-old brother had been involved in a physical altercation with another student at school, and the infant's father stopped the other student and the other student's sister when they were walking home from school. The CPI interviewed the other student and his sister, who reported the other student had been involved in a fight with the infant's brother. The next day, they were walking home from school, near the brother, when a man jumped out of a car and told the brother to punch the other student in the face and the brother did so. The student and his sister could not identify the man, but later heard the brother say the man was his cousin. The CPI noted the brother was reluctant to speak and stated his parents told him not to answer any questions about the incident. The 8-year-old brother denied any knowledge of the incident. The school principal reported no major concerns with either the 10-year-old brother or the other student. The parents both denied the incident. In January 2022, while the investigation remained pending, DCFS received a report that the infant tested positive for marijuana at birth. The report was taken for related information. In February 2022, the CPI visited the home, observed the home to be safe and appropriate, and discussed safe sleep with the mother. DCFS unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 97	DOB: 09/2020	DOD: 04/2022	Accident
Age at death:	19 months		
Cause of death:	Multiple blunt force trauma		
Reason for review:	Three unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nineteen-month-old was pronounced deceased at the scene of a two-car accident. Newspapers reported the paramour of the toddler's father was driving and pulled over to the side of the road, where their vehicle was rear-ended by another driver. DCFS did not investigate the toddler's death.

Reason for Review: In July 2021, DCFS received a report that the father used cocaine and ketamine while caring for the then 9-month-old toddler, the toddler had cigarette burns on his legs, and he often had clothing that was torn and wet with urine after visiting with the father. The mother reported to the CPI that nine days earlier, the child had mouse bites on his face and stomach after the father returned the child to her. She stated she would not allow the child to visit the father until after their next family court date in August, and she agreed to bring the toddler to the doctor. The CPI assessed the toddler safe in his mother's care. The father denied the allegations, reported he had already scheduled a hair follicle toxicology screening because the mother had accused him of drug use, and stated the mother violated the custody order because he had not seen the toddler in over two weeks. Collateral contacts reported no concerns about the father's care, and the toddler's primary care provider observed no injuries. In August 2021, DCFS unfounded the investigation for burns by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect. Ten days later, DCFS received a report that the toddler had bruises on his face and body after a visit with his father, and the father's home was crowded with animals and had a pest infestation. The mother stated the court had ordered her to resume visits with the father.

She brought the toddler to the emergency room for an evaluation and the treating physician reported no injuries, but noted the toddler appeared to have a facial rash and mild diaper rash that was resolving. The mother stated she obtained an emergency order of protection against the father. The CPI visited the father's home and observed no signs of infestations. The father denied the allegations, reported the court held the mother in contempt for denying him visits. Nine days after the Hotline report, DCFS unfounded the investigation for burns by abuse; cuts, bruises, welts, abrasions, and oral injuries by abuse; environmental neglect; and substantial risk of physical injury/environment injurious to health and welfare by neglect. In November 2021, DCFS received a report that law enforcement responded to the mother's home for a report that the then 14-month-old toddler cried for two hours. The reporter stated police found the door open; the toddler was alone, had a full diaper, and was crying in his crib; and the mother and her paramour appeared intoxicated and drug paraphernalia was observed throughout the home. The mother denied the door was open and stated she had called the landlord because the door jamb was broken, and she and her paramour believed police had forced the door open. Both the mother and paramour denied using marijuana around the toddler and reported they kept all related items out of reach. The toddler was assessed safe. The probation officer of the mother's paramour reported the paramour tested negative for all drugs, had previously served time for battery to the mother, but had completed services and reported things were going well in the home. The landlord reported no concerns about the family and stated he had no knowledge of the door being damaged prior to the incident. In December 2021, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 98	**DOB: 04/2022**	**DOD: 05/2022**	**Accident**
Age at death:	4 weeks		
Cause of death:	Asphyxiation due to airway obstruction in unsafe sleep environment		
Reason for review:	Open intact family services case at time of child's death; two indicated and two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-week-old was found unresponsive in her parents' bed by her mother around 7:30am. The mother called 911 and began CPR. The infant was transported by ambulance to the hospital, where she was pronounced deceased. The mother reported she awoke at 4:00am, removed the infant from her bassinet, and returned to bed with the infant's father and laid the infant on her chest. DCFS investigated the infant's death and indicated the mother for death by neglect.

Reason for Review: The father was the alleged perpetrator in investigations involving children with two different women. In August 2021, DCFS opened two investigations involving the infant's parents. The first investigation was opened after an altercation between the parents at the father's home and a report that the mother left the 8-month-old brother in his carrier in the street which both parents denied. The investigation was later unfounded. The second investigation involved reports that the father placed his fingers in the mouth of the infant's then 3-year-old sister until she began choking and gagging, and that the father had previously hit the 5-year-old brother. The father denied the incident and the pediatrician had no concerns. The father was unfounded for substantial risk of physical injury/environment injurious to health and welfare. In September 2021 DCFS opened two investigations involving the father, the infant's paternal half sibling and that sibling's mother. Allegations included behavioral health concerns of the 8-year-old and that the father was abusive to the child's mother. The half-brother's mother downplayed the seriousness of the incident and refused to obtain an order of protection against the father. DCFS indicated both investigations against the father for substantial risk of physical injury/environment injurious to health and welfare by neglect. The paternal half-brother's mother declined intact family services but accepted community-based referrals. In January 2022, DCFS opened an intact family services case. Recommended services included counseling, domestic violence services, parenting education, and early intervention services for the infant's then 11-month-old brother. The intact worker conducted weekly visits with the family. The mother reported she had an active order of protection against the father and was

pregnant with the infant. The intact worker discussed safe sleep with the mother and observed safe sleep arrangements for each of the children. In February 2022, the mother completed parenting classes. In April 2022, the mother began domestic violence classes and the intact worker's visits were reduced to bi-weekly because the family was cooperating with services. That month, the mother gave birth to the infant and the intact worker discussed safe sleep with the mother and confirmed the family had a crib for the infant. The intact case remained open at the time of the infant's death.

Child No. 99	**DOB: 02/2005**	**DOD: 06/2022**	**Accident**
Age at death:	17 years		
Cause of death:	Multiple injuries due to probable motor vehicle accident		
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 brought to the hospital by friends. The teen's twin reported they had been in a car accident. DCFS received a report that the teen and his twin required a transfer to a different hospital due to the severity of their injuries, but their father refused the transfer. The teen died of his injuries, and the father took the twin out of the hospital against medical advice. The reporter also stated the teen and his twin were involved in a gang. DCFS investigated the teen's death. Hospital staff reported the teen needed transport to a trauma center but died before the ambulance arrived. The mother reported she received a call when they were in the accident but was unable to go to the hospital because she had two young children and called the father to send him to the hospital. Both parents reported they were not informed of the seriousness of the injuries. The father and the twin reported the twin left the hospital on his own. Law enforcement was unable to locate an accident scene and reported they had been looking for the teen and his twin in relation to a possible carjacking. DCFS unfounded its investigation of the teen's death for death by neglect and medical neglect.

Reason for Review: In April 2021, DCFS received a report that the parents allowed the teen and his twin to use and sell drugs and bring guns into the home which were left in reach of the teen's then 2-year-old sister. The mother reported the father did not live in the home and denied the allegations. She added they lived in Section 8 housing and received inspections from the housing authority. The CPI noted no concerns on the home safety checklist. Both the teen and his twin denied the allegations. The CPI observed the twin with casts on his foot and arm. The twin reported he was in a car accident in December 2020 and was in a coma for 10 days. Local police reported they arrested the teen in February 2021 for aggravated unlawful use of a weapon but had no other involvement with the family. A collateral contact reported no concerns. DCFS unfounded the investigation due to inadequate evidence to support the allegations.

Child No. 100	**DOB: 07/2021**	**DOD: 06/2022**	**Accident**
Age at death:	10 months		
Cause of death:	Anoxic encephalopathy due to asphyxia (unsafe sleep environment)		
Reason for review:	Closed intact family services case and unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Ten-month-old was found unresponsive, in an adult bed, by his maternal grandfather. He was brought by private car to the hospital, where he was intubated, then airlifted to a children's hospital. Two days later, he was removed from life support and pronounced deceased. The grandfather reported he fed the infant, the infant fell asleep, and he placed the infant in an adult bed with a stack of comforters around him to prevent him from falling off the bed. The grandfather reported he then went to a neighbor's home. He was out of the home for approximately 40 minutes. The infant's 8-year-old brother was playing outside at the time. Another 18-year-old grandson was in the home at the time, but the grandfather did not

tell him he was leaving, and he was not responsible for the children. The mother reported she had a pack-and-play for the infant, but when he stayed with his grandfather, he would sleep on the grandfather's bed while the grandfather slept on the sofa. The DCFS investigation into the infant's death remains pending.

Reason for Review: Upon the infant's birth in July 2021, DCFS received a report the mother tested positive for marijuana, but hospital staff had no medical concerns for the infant and did not observe withdrawal symptoms. The report was not taken for investigation. One week later, DCFS received a report that the infant was sent to the hospital for failure to thrive due to rapid weight loss and was discharged the same day with strict guidance to take the infant to see his primary care provider and return to the hospital the following day, but the mother refused to bring him back to the hospital. The CPI saw the family at home that day, and the mother reported she was in pain from giving birth to the infant by c-section, and was not supposed to drive, but had no one to help her. The CPI helped the mother make an appointment. The infant's 8-year-old sibling reported feeling safe at home. The infant was observed sleeping in a bassinette and the CPI documented discussing safe sleep with the mother. The CPI spoke to the infant's medical providers, who reported the mother had been following up with his care, he was gaining weight, and they did not believe the infant was medically neglected. The mother agreed to intact family services. In September 2021, DCFS unfounded the investigation for medical neglect. At the beginning of the intact case, the family was living with the children's maternal grandfather. The intact worker made regular visits to the home and assisted in obtaining an IEP for the 8-year-old sibling. The mother obtained a new pediatrician for the infant and brought him for his appointments consistently. In May 2022, DCFS closed the intact case as successful because the mother cooperated with services and obtained housing.

Child No. 101	**DOB: 04/2020**	**DOD: 06/2022**	**Accident**
Age at death:	2 years		
Cause of death:	Drowning in a swimming pool		
Reason for review:	Closed intact family services case and unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Two-year-old was found face down in an above-ground swimming pool at his aunt's home. The toddler was taken to the hospital by ambulance and was pronounced deceased. The toddler had lived with his aunt since 2021, and she had obtained legal custody. The gate to the pool had been locked, but the fence appeared bent, as if the toddler climbed over it. The aunt reported the toddler knew he was not allowed to go to the pool without an adult and his floaties. The aunt and grandparents were in the front yard at the time of the incident, and the toddler's 8-year-old and 15-year-old cousins, and a cousin's friend, were inside the home. The aunt reported he was missing only for a few minutes. No one witnessed the toddler going to the pool, but the 15-year-old cousin stated she had seen the toddler climbing the fence a few days earlier, though she did not tell the aunt about the incident. DCFS investigated the toddler's death and unfounded the investigation for death by neglect.

Reason for Review: In 2020, DCFS opened an intact family services case for the mother after the mother admitted to methamphetamine use and having unstable housing. Recommended services included substance use treatment, individual therapy, and housing assistance. The toddler's then 5-year-old maternal half-sister went to live with her father full-time because the mother lacked stable housing. The half-sister's father also offered to care for the then 1-year-old toddler, but the mother refused. The toddler went to live with his maternal aunt. In June 2021, DCFS received a report that the mother was using methamphetamine daily while caring for the toddler and was leaving the toddler with multiple family members because she lacked stable housing. The reporter added the mother was living with a family member who also used methamphetamine, and the family member's children were currently in foster care. The CPI and intact worker met with the mother at the home of the maternal grandmother. The mother completed a toxicology screening, but the report noted the sample had been altered. The mother had failed

to complete several requested toxicology screenings during her intact family case; the screenings she did complete were negative. While the investigation was pending, the intact worker spoke with the aunt about obtaining guardianship for the toddler. The intact worker had requested that a neglect petition be filed but the State's Attorney did not reply. In August 2021, DCFS unfounded the child protection investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect due to insufficient evidence to support the allegation. In September 2021, the State's Attorney stated they had not yet reviewed the petition. That month, DCFS closed the intact family services case unsuccessfully because the mother could not be located and was not engaged in any services. The toddler continued to live with his aunt until his death.

Child No. 102	**DOB: 10/2004**	**DOD: 06/2022**	**Accident**
Age at death:	17 years		
Cause of death:	Blunt trauma of the head due to motor vehicle crash		
Reason for review:	Two pending child protection investigations at time of child's death		
Action taken:	Full investigation pending		

Narrative: Seventeen-year-old was a passenger in a vehicle driven by a friend when the car hit a utility pole. The teen was not restrained in the vehicle and died from his injuries. The friend was arrested and charged with DUI. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In July 2021, DCFS received a report that law enforcement arrested the teen's mother for battering the teen. The CPI met with the teen and his older sister at the sister's home. The teen had visible scratch marks on his neck. He stated his mother was angry because his uncle had made treatment decisions regarding his grandmother's care. Both the teen and his sister denied the mother had ever attacked them prior to the incident, and both reported their mother had been sober, but they believed she was drinking again. The sister and her paramour were not present for the incident. The sister reported she was the mother's power of attorney, and the mother had cirrhosis of the liver and heart failure. Family members reported the mother had a history of psychiatric hospitalizations, the teen's grandmother had chronic obstructive pulmonary disease (COPD) and was in hospice care, and the teen's older brother had died of an overdose two years earlier. The sister's home was observed to be free of safety concerns, and the teen was assessed as safe in the sister's care. Four days later, DCFS received a report that the mother was admitted to a psychiatric hospital following her incarceration. In August 2021, the CPI met with the mother at the hospital. The mother stated she had relapsed on alcohol, blacked out, woke up in jail, and did not remember hitting the teen. She denied she had ever hit her children before. The mother stated the hospital had connected her with a psychiatrist and therapist and she had appointments arranged following her discharge. The mother agreed to intact family services, but the case was not opened before the death. In October 2021, while the previous investigation remained pending, DCFS received a report that the teen was in a household with his mother, who had overdosed multiple times, and someone in the home was in hospice care. The CPI met with the teen at home, who stated his mother was hospitalized at that time, and the name given for his mother in the Hotline report was instead the name of his grandmother, who resided in a nursing home. The teen reported that one week earlier, his mother and grandmother both overdosed. It was believed they both overdosed on morphine, but not at the same time. He stated he lived in the home with his sister and his great-grandmother, and the home appeared free of safety concerns. In November 2021, the teen's grandmother died. Both investigations remained pending at the time of the teen's death in June 2022. DCFS later indicated the first investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse. DCFS unfounded the second investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 103	DOB: 08/2015	DOD: 06/2022	Accident
Age at death:	6 years		
Cause of death:	Multiple blunt force injuries due to motor vehicle striking fixed object		
Reason for review:	Split custody		
Action taken:	Investigatory review of records		

Narrative: Six-year-old and six of his siblings, ages 1 to 15, were passengers in a car driven by their mother when the car crashed into a median. The child was unrestrained, thrown from the vehicle and died four days later. Law enforcement reported only two children were wearing seatbelts during the accident. DCFS opened an investigation following the accident. The mother reported all children had been wearing seatbelts, and the 1-year-old sister was in a car seat. She tested positive for alcohol and marijuana and was charged with an aggravated DUI and child endangerment. DCFS indicated the mother for death by neglect; head injuries by neglect; internal injuries by neglect; bone fractures by neglect; cuts, bruises, welts, abrasions, and oral injuries by abuse and by neglect; and substantial risk of physical injury/environment injurious to health and welfare by neglect. Following the death, the court granted DCFS temporary custody of the surviving siblings.

Reason for Review: In June 2022, two weeks before the child's death, juvenile delinquency court ordered the child's 16-year-old brother to be held in juvenile detention for approximately six weeks, followed by three years of probation and ordered him into the custody of DCFS. Recommended services included mentoring, anger management, trauma focused therapy, and family therapy with the mother, and brother to comply with probation recommendations. Four days later, the placement worker spoke with the mother, who stated she did not need services, and the father also needed to be held accountable. At the time of the child's death, the 16-year-old brother remained in detention and the placement case remained open.

Child No. 104	DOB: 07/2019	DOD: 06/2022	Accident
Age at death:	2 years		
Cause of death:	Residential swimming pool drowning		
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death; one indicated and two unfounded child protection investigations, and closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old was found face down in a pool. The toddler's paternal grandparents, who were caring for him at the time, reported the toddler had asked to go swimming, and the grandmother stated she would take him after she put dinner in the oven. A few minutes later, the grandparents found him in the pool; they pulled him out and called 911. He was transported by ambulance to the hospital, where he was pronounced deceased. DCFS investigated the toddler's death and unfounded the grandparents for death by neglect.

Reason for Review: In December 2020, DCFS received a report that the father gave the child's 6-year-old sibling marijuana. The investigation was unfounded, but the father agreed to an intact family services case. This case closed after the father completed services. In June 2021, DCFS received a report that the toddler's half-brother required stitches from playing on a trampoline at the mother's home. It was also reported that the mother burned the toddler on the face with a cigarette. The mother denied that she burned the toddler, and the investigation was ultimately unfounded. In August 2021, DCFS opened another investigation after receiving a report that the mother was using drugs. DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect and opened an intact family services case. The intact worker implemented a safety plan for the half-brother to be in father's care. In December 2021, DCFS received a report that the mother, who was homeless, had been intoxicated while visiting with the child the prior weekend and had recently tested positive for

methamphetamine and marijuana. The father reported that he was seeking full custody of the half-brother. DCFS later unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect. In May, DCFS received a report that that the half-brother had a circular mark on his arm while in the care of his father. The intact family services case and child protection investigation both remained open at the time of the toddler's death. DCFS later unfounded the father for burns by abuse.

NATURAL

Child No. 105	DOB: 06/2021	DOD: 07/2021	Natural
Age at death:	7 days		
Cause of death:	Hypoxemic respiratory failure due to extreme prematurity of 24 weeks gestation due to pulmonary hemorrhage; significant contributing conditions of grade 4 intraventricular hemorrhage, severe anemia, severe metabolic acidosis		
Reason for review:	Open intact family services case at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-day-old died at the hospital where he had been born and remained until his death. The newborn and his twin sister were born premature, at 24 weeks gestation, and the newborn was intubated and cared for in the NICU. The newborn's mother had no prenatal care and tested positive for marijuana, but the infant's urine toxicology screening was negative. DCFS did not investigate the newborn's death.

Reason for Review: In November 2020, DCFS received a report that police responded to a verbal disturbance at the hotel the family was living in, and the newborn's siblings, then 7 months, 2 years, and 4 years, were present. The newborn's 4-year-old brother brought the responding officer to the window, where he observed the parents fighting. Police reported there was an active warrant for the mother's arrest for a seat belt and child safety restraint citation, but they did not arrest her due to her financial and parental status and over-population of the county jail. Police also reported the room had a bad odor, and there was trash and food on the floor. The parents admitted to a verbal argument but stated they left the room because they did not want to argue in front of the children. DCFS indicated the parents for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. The parents agreed to intact family services, and DCFS opened the intact case at the close of the investigation. The recommended services included housing, daycare, and domestic violence services. The intact workers noted the parents were wary of caseworkers and minimally cooperative and not receptive to all services offered. Ten days before the newborn's birth, the mother admitted she was six months pregnant and had been afraid to disclose her pregnancy to the intact worker. In June 2021, the newborn and his twin sister were born by emergency c-section, and the mother reported the twins would remain hospitalized for at least three months. The intact case remained open at the time of the newborn's death.

Child No. 106	DOB: 02/2002	DOD: 07/2021	Natural
Age at death:	19 years		
Cause of death:	Hypertrophic cardiomyopathy		
Reason for review:	Deceased was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Nineteen-year-old was pronounced deceased at the hospital following an asthma attack that started while he was playing basketball. The teen used his inhaler, but he still could not breathe. Someone called 911, and he was transported to the hospital by ambulance. DCFS did not investigate the teen's death.

Reason for Review: The teen came into care of DCFS at the age of 6 years. He experienced 16 placements while in care, including three hospitalizations. In 2014, the teen was placed in a specialized foster home where he remained until his death. The teen's foster parent reported he was appropriate in the home, stable in the placement, and he had regular contact with his caseworker. At the time of his death, the teen's permanency goal was independence, and he had been making progress toward that goal.

Child No. 107	DOB: 02/2021	DOD: 07/2021	Natural
Age at death:	4 months		
Cause of death:	Viral pneumonia with bronchitis, meningitis, and myocarditis		
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old was found unresponsive around 7:00am. The mother reported she awoke at 5:00am to feed him a bottle and placed him back in his pack-and-play around 5:30am. Emergency medical services transported the infant to the hospital, where he was pronounced deceased. DCFS investigated the infant's death and unfounded the investigation for death by neglect following the results of the infant's autopsy.

Reason for Review: In May 2021 DCFS received a report that the infant's 11-year-old cousin, who was in the care of the infant's parents, frequently came to school with bumps on his head and was recently observed with lacerations on the side of his face. The mother reported that her nephew, who was non-verbal and visually impaired, had been sent to the United States by his mother, who could no longer care for him. School personnel reported that the minor had been observed running into things and hitting his head during school hours. They denied concerns of abuse but felt the family needed support due to the child's special needs. The investigation was unfounded for cuts, bruises, welts, abrasions, and oral injuries by neglect against the infant's mother, and an intact family services case was opened. In June 2021, DCFS received a second report after the mother brought the infant to a crisis nursery to be cared for while the infant's cousin was in surgery. The infant was observed with cradle cap, scratches from long fingernails, and poor grooming. The CPI saw the infant at the nursery and observed him to be clean and well-nourished, but documented cradle cap and multiple scratches. The CPI observed that the home appeared clean and other six children in the home, ranging in ages from 1 year to 11 years, appeared well-groomed and free of any personal hygiene concerns. The investigation was pending at the time of the infant's death. The investigation was later unfounded.

Child No. 108	DOB: 11/2004	DOD: 07/2021	Natural
Age at death:	16 years		
Cause of death:	Left ventricular hypertrophy		
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 at an amusement park with his family when he began to walk slowly, stumbled, and collapsed. He was transported to the hospital, and medical staff were unable to revive him. The teen had a history of developmental delay and possible fetal alcohol syndrome. DCFS did not investigate the teen's death.

Reason for Review: The teen and his two older biological siblings lived with their paternal aunt, who had been their legal guardian since 2013. In April 2021, DCFS received a report that the teen's 18-year-old sister and then 18-year-old brother were locked in their bedrooms all day, with windows that were nailed shut, without phones to prohibit them from communicating with anyone, and they were only allowed to leave their rooms to use the restroom or eat. Shortly after the initial report, DCFS received an additional report that the aunt did not provide hygiene products to the siblings, bullied the children, did not approve of the brother dating a man, and she and her husband used alcohol and marijuana. The teen's brother, who shared his room with the teen, stated there was a latch on their door because he liked to sneak out at night, and he lost phone privileges for sending inappropriate pictures and videos. The teen's sister denied all the allegations in the report. All three youths stated they felt safe in the home, and the CPI observed no visible signs of abuse or neglect. The aunt stated the latch on the door was installed following an incident when

the brother snuck out at night, stole her car keys, and took her car. She stated the latch was approved by DCFS as long as it was not a fire hazard. The aunt stated the brother lost his phone privileges for sending nude pictures and videos to a man he met online, and after losing his phone, the brother took the sister's phone to contact the man. In May 2021, while the investigation was pending, DCFS received related information reports about the 18-year-old sister's mental health issues and her desire to leave the home. DCFS provided the sister with information for a shelter but did not take custody because she was an adult. The sister moved in with the biological mother. In May 2021, DCFS unfounded the investigation and the aunt and uncle expressed a willingness to continue caring for the teen and his brother.

Child No. 109	**DOB: 07/2021**	**DOD: 07/2021**	**Natural**
Age at death:	1 day		
Cause of death:	Right-sided congenital diaphragmatic hernia		
Reason for review:	Two pending child protection investigations at time of child's death; one indicated and two unfounded child protection investigations within one year of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: One-day-old was born premature, at 35 weeks gestation, with a hole in his diaphragm. He died the following day. His mother received prenatal care and was aware there would be medical issues. DCFS did not investigate the newborn's death.

Reason for Review: In the year before the newborn's death, DCFS opened two investigations regarding the newborn's mother, one investigation regarding the newborn's great grandmother, and two investigations of the mother's once-paramour and father of the newborn's half-brother, who was 1 year old at the time of the newborn's death. In September 2020, DCFS received a report that the newborn's great grandmother was seen hitting the newborn's 7-year-old sister on the back of her head during remote learning. The 7-year-old, 6-year-old, and 4-year-old siblings stated their great grandmother yelled but did not hit them, and they felt safe with their great grandparents, but they were afraid of their mother. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse. In November 2020, DCFS received a report that the father of the newborn's then 8-month-old half-brother was on probation for battery charges, recently tested positive for amphetamines and cannabis, had lost significant weight, was getting sores on his face, and was spending substantial time with the 8-month-old. The mother's then paramour admitted to recent drug use. In January 2021, DCFS indicated the paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect due to his admission of using drugs. In December 2020, while the investigation against the paramour was pending, DCFS received a report that the newborn's mother molested her 15-year-old cousin while babysitting her 12 years earlier. In February 2021, DCFS unfounded the investigation due to insufficient evidence. In March 2021, DCFS received a report that the paramour was arrested after a domestic violence incident, during which the newborn's half-siblings were present. Police stated the arrest was his third for domestic violence, and they were called to the mother's home at least once per month. The next day, the mother allowed the CPI to see the 1-, 3-, and 5-year-old children at the door but did not allow her to interview them. The children were observed to be clean and free of obvious signs of abuse or neglect. The mother reported the paramour did not live in the home. The child protection investigation remained pending at the time of the newborn's death. DCFS later indicated the paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect. In June 2021, DCFS received a report that the newborn's 8-year-old sister had bruises on her inner thighs and a pinch mark and bruises on her arm. The reporter stated the mother pinched the 8-year-old after the 8-year-old pinched her 6-year-old sister, but the mother told the reporter the bruising was from poison ivy. The investigation remained pending at the time of the newborn's death the following month. CPIs made three unsuccessful

attempts to see the children before the newborn's death. DCFS later unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse.

Child No. 110	**DOB: 02/2021**	**DOD: 07/2021**	**Natural**
Age at death:	5 months		
Cause of death:	Viral pneumonia with bronchitis		
Reason for review:	One unfounded and one indicated child protection investigation and closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-month-old was found unresponsive, on his stomach, in his crib, by his 15-year-old mother. The infant's mother reported she fed him a bottle then placed him on his stomach in the crib approximately one hour earlier, and she had checked on him 30 minutes earlier. DCFS investigated the infant's death and unfounded the investigation for death by abuse.

Reason for Review: From June 2020 through May 2021, the mother's 5-year-old paternal half-sister was placed in a fictive kin foster home. In July 2020, DCFS opened an intact family services case for the mother's family after the infant's grandfather relapsed in his drug use and stopped assisting with parenting. In August 2020, the infant's then 14-year-old mother reported she no longer wished to live with her mother, the infant's grandmother, and went to stay in the home where the mother's paternal half-sister had been placed. The intact caseworker continued to assist her while she was out of the home. The mother received prenatal care. In November 2020, DCFS opened an investigation against the infant's grandmother after she relapsed in her drug use, required inpatient hospitalization, and could no longer care for the 16-year-old sister of the infant's mother. The mother's 16-year-old sister went to stay with a relative. DCFS indicated the infant's maternal grandmother for substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant's mother and the mother's 16-year-old sister. In December 2020, the court ordered the return of the mother's 5-year-old paternal half-sister to the care of her father, the infant's grandfather, and the mother decided to return to his care as well. In January 2021, the intact family services case closed as the infant's grandmother no longer had her children in her care. In February 2021, DCFS opened an investigation of the infant's mother after the infant's birth because the mother reported she planned to live with her parents, who each had a history of drug use. The mother had moved back in with her father, who continued to participate in substance use treatment and completed negative toxicology screenings. The mother took the infant for his regular checkups, the infant's doctor reported no concerns, and DCFS observed the home to be appropriate. Eight days after the Hotline report, the investigation was closed as unfounded at the initial stage.

Child No. 111	**DOB: 12/2008**	**DOD: 07/2021**	**Natural**
Age at death:	12 years		
Cause of death:	Perforation of the cecum due to complications of chronic constipation		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation; report to Director April 6, 2022		
	See Death and Serious Injury Investigation 11		

Narrative: Twelve-year-old was pronounced deceased at the hospital after going into cardiac arrest during surgery for an intestinal perforation. She had been admitted to the hospital the day before for gastrointestinal issues including chronic constipation. At admission, her abdomen appeared distended. DCFS investigated the child's death and unfounded the investigation for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect with the rationale that the mother brought the child to the hospital when she was in pain, and there was insufficient evidence to support that she could have prevented the intestinal perforation.

Reason for Review: In September 2020, DCFS received a report that the child and her three sisters, then ages 6 to 15, had poor school attendance, the child could not attend school because she did not have an up-to-date physical, and her 15-year-old sister was not receiving her medication for juvenile arthritis. The children reported their mother was gone at night and school staff reported concerns about the mother's mental health and possible substance use. The CPI met with the family and learned the child had not been seen by her primary care provider since before the pandemic, and had a history of irregular bowel movements, for which the mother gave her natural supplements. The mother scheduled a school physical for the child. The mother reported the 15-year-old sister had completed lab work for liver function and was receiving treatment. The 15-year-old sister watched the other children for short periods of time. The children reported they felt safe at home, denied physical abuse, and denied witnessing their mother use drugs or alcohol. A social worker at the hospital where the 15-year-old received treatment reported the sister required monthly treatment, but they had not seen her in over six months and had been unable to contact the mother or leave her voicemail messages. The children's primary care provider reported she had last seen the children in 2018. The child was prescribed a laxative for constipation and had been referred to a specialist. The CPI directed the mother to have all four children seen by their primary care provider and to take the 15-year-old to the hospital for immediate treatment. In December 2020, the mother stated the children had seen their primary care provider. She stated the child took laxatives and mineral oil for her gastrointestinal issues, but she was only able to get her to take it twice per week because the child disliked the medication. The mother stated the 15-year-old was removed from her medication and was given an injection every six months for her arthritis. A collateral contact reported no concerns with the mother's supervision or care for the children and their medical issues. DCFS unfounded the investigation for medical neglect, inadequate supervision, and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 112	**DOB: 03/2007**	**DOD: 07/2021**	**Natural**
Age at death:	14 years		
Cause of death:	Malignant neoplasm of connective tissue		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old died after she had been diagnosed with lung cancer and had been receiving treatment. DCFS did not investigate the teen's death.

Reason for Review: In February 2021, DCFS received a report that the teen's mother was physically violent with the teen during a fight with the teen's sibling, and the teen did not feel safe around her mother. At the time of the report, the teen was in the hospital for chemotherapy and stated she wanted to stay with her maternal grandparents upon discharge. The teen's mother and 12-year-old brother denied the incident happened. The grandparents agreed to take the teen in after discharge but stated they had no concerns about the mother. The teen's doctor reported no concerns and stated the mother was consistent with the teen's treatments. A few weeks later, the teen reported she missed her mother and siblings and returned home. The CPI visited the teen at home, and the teen reported she felt safe and recanted her earlier statements. In April 2021, DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by abuse. In May 2021, DCFS received a report that the teen was re-admitted to the hospital for pain and dehydration following a surgery, and the mother brought the teen home from the hospital before receiving discharge paperwork and oxygen for the car ride. The mother admitted to taking the teen home before receiving discharge papers and oxygen and stated the teen had never needed oxygen before. The CPI assessed the children as safe in the home, and the mother agreed to take the teen to urgent care to check her oxygen levels. The urgent care provider reported the teen did not need oxygen at that time. The investigation remained pending at the time the teen died. DCFS later unfounded the mother for medical neglect.

Child No. 113	DOB: 07/2021	DOD: 07/2021	Natural
Age at death:	0 days		
Cause of death:	Multiple anomalies in addition to trisomy 18		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn had been born with Trisomy 18, a known lethal anomaly, and died at the hospital approximately two hours after her birth. The newborn's mother received prenatal care and medical staff had no suspicion of neglect or substance use. DCFS did not investigate the newborn's death.

Reason for Review: In September 2020, DCFS received a report that the newborn's mother and six siblings, ages 1 to 11, lived in a home without running water; the mother and her paramour frequently drank alcohol and fought in front of the children; and the police were often called to the home. The CPI met with the mother and paramour; the mother reported her children lived with family members, but they did visit her home. She stated they had running water, but the pipes leaked in the basement, so she turned off the water when it was not in use, and the municipality had recently turned off the water. The mother denied drinking, drug use and domestic violence. Her paramour disclosed a history of domestic violence with the mother and stated the latest incident had happened three months ago and resulted in him spending two days in jail. The children reported they used a neighbor's bathroom when they visited their mother. The children were all observed to be free of visible injuries. The maternal grandmother reported the mother spent a lot of time with the children at the grandmother's home. In November 2020, DCFS unfounded the investigation for environmental neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect because the children did not live with their mother, the children's caregivers reported no concerns about the mother's care, and the children denied witnessing domestic violence between their mother and her paramour.

Child No. 114	DOB: 11/2017	DOD: 08/2021	Natural
Age at death:	3 years		
Cause of death:	Respiratory distress due to cerebral palsy; significant contributing conditions of hypoxia, ischemic encephalopathy, slow weight gain, and seizures		
Reason for review:	Open intact family services case at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old medically complex toddler was found unresponsive after she had been put down for a nap. The toddler's maternal grandfather called 911 while her mother performed CPR until paramedics arrived. She was pronounced deceased at the hospital. The toddler had diagnoses of brain injury at birth, cerebral palsy, and a history of failure to thrive. The family reported they provided her feedings and medications as usual in the days prior to her death. They stated they took the toddler to see her pediatrician three days earlier. DCFS investigated the death and unfounded the investigation for death by neglect.

Reason for Review: In October 2020, DCFS received a report that the toddler arrived at the hospital with a laceration on the side of her head from an injury that occurred two days prior. Staff reported concerns as the child had limited mobility due to her medical conditions. The hospital admitted the toddler for failure to thrive. Medical staff noted no other injuries. The parents stated they noticed the injury a few days prior, thought it may have been from a headband or barrette, and attempted to treat it at home. In March 2021, DCFS indicated the investigation for cuts, bruises, welts, abrasions, and oral injuries by neglect with the rationale that the injury was not intentional, but the toddler was not mobile or verbal, had a complex medical history, and she was not brought to the ER immediately. DCFS opened an intact family

services case. The toddler's primary care provider stated her only concern was the toddler's weight and that the family seemed to struggle sometimes with understanding how to use her medical machines. She later stated she felt the family needed better communication from the toddler's care team to reduce confusion and mixed information. The family's visits were held in-person weekly until July 2021, at which point they were reduced to every other week because the family was making progress in their services. Six days before the toddler died, the family was informed their case would be closed and a final visit was scheduled for the day after the toddler's death. The intact family services worker learned of the toddler's death when she arrived at the home for the final visit.

Child No. 115	**DOB: 10/2012**	**DOD: 08/2021**	**Natural**
Age at death:	8 years		
Cause of death:	Multisystem organ dysfunction due to SARS-COV2 pneumonia due to E. coli urinary sepsis due to enterococcus urinary sepsis		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-year-old medically complex child died at the hospital, where she had been admitted approximately one week earlier for multi-organ dysfunction syndrome, E. coli infection, an enterococcus saecalus uroseptis infection, and COVID pneumonia. The child had existing neurological delays, quadriplegic cerebral palsy, seizure disorder, obstructive sleep apnea, hip dysplasia, and profound intellectual disability. She required supplemental oxygen, a g-tube for feeding, and other home medical equipment. The child's mother had been exposed to someone with COVID two weeks before the child's death and attempted to stay away from the child. Three days later, she noticed the child appeared unwell, so she took her for evaluation and found the child had COVID but stated the child had been okay. One week before her death, the mother noticed the child was having difficulty breathing, so she called 911, and the child was transported to the hospital. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In June 2020, DCFS received a report that the mother failed to keep the child's medical appointments or refill her seizure medication. The mother stated she had taken her to appointments prior to the COVID pandemic, but she felt it had become unsafe to do so, and she maintained contact with the hospital social worker. The family received in-home care during the day and overnight. The child was non-verbal but appeared jovial and free of injuries. The CPI observed the child's medical equipment and adequate food for the child. The home was assessed as safe. The mother declined intact family services. In July 2020, the CPI submitted a nursing referral. The child's primary care physician stated the child's medical team communicated to ensure the child could be seen by all her providers when she was in the clinic, and they had become frustrated with the mother missing appointments and lack of communication with the treatment team. The child had an appointment scheduled for the following day, but the transportation company had canceled her transport. Medical staff reported the child was scheduled for an appointment in August 2020. Three days before the appointment, the CPI met with the family to confirm the child would attend the appointment and the mother stated the appointment was rescheduled for the following month. The CPI called and spoke with the medical staff, who confirmed the child's next appointment had been rescheduled for September. The mother again declined intact family services and stated the difficulty with keeping appointments was due to unreliable transportation. The child's in-home nurses denied any concerns about the mother's care for the child. The CPI requested a court-ordered intact family services case to monitor the child's medical appointments and assist with arranging transportation, but the State's Attorney did not file a petition. DCFS indicated the mother for medical neglect due to the severity of the child's medical conditions that could result in long-term damage if not treated appropriately.

Child No. 116	DOB: 06/2021	DOD: 08/2021	Natural
Age at death:	6 weeks		
Cause of death:	Cardiorespiratory arrest due to congenital hypoplastic left heart due to high risk following complex heart surgery		
Reason for review:	Closed intact family services case and unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-week-old was pronounced deceased at the hospital after being found unresponsive at home. The baby had congenital cardiac condition, hypoplastic left heart syndrome, that required surgery a week after his birth. He was discharged home three days before his death. The infant required a g-tube for feeding. The parents reported lying him down after feeding him around 11:00pm, and shortly after midnight, he became fussy and stopped breathing. His parents called 911, and the infant was transported to the hospital by ambulance. DCFS unfounded its investigation of the infant's death for death by abuse and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In 2019, DCFS opened an intact family services case following the father's indicated investigation involving his children with another mother for substantial risk of harm because of concerns about substance use and domestic violence. The father completed an outpatient substance use disorder treatment program but continued to use marijuana. He did not participate in domestic violence services. In December 2020, DCFS received a report that the infant's mother struck the mother of the father's other children, resulting in a black eye, while the children were present. At the time of the investigation, the infant's mother and father lived together, and the siblings' mother came to pick up her children from the home. The father reported the paternal siblings' mother instigated the altercation, not the infant's mother. DCFS unfounded the infant's mother and father for substantial risk of physical injury/ environment injurious to health and welfare by neglect. The intact family services case closed in July 2021.

Child No. 117	DOB: 11/2003	DOD: 08/2021	Natural
Age at death:	17 years		
Cause of death:	Left ventricular hypertrophy		
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death; two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old died at the hospital where she had been brought during an asthma attack. During intubation, she stopped breathing and medical staff had difficulty inserting the breathing tube due to food in her esophagus. DCFS did not investigate the teen's death.

Reason for Review: In December 2020, DCFS received two reports on the teen's family. The first report stated the mother's home had garbage and rotting food strewn throughout, a pest infestation, and the teen and her 9-year-old and 15-year-old sisters possibly had lice or fleas. The mother denied environmental neglect and was able to navigate her home in her wheelchair. The relative who owned the home denied any concerns. The children appeared clean, with no signs of abuse or neglect, and reported having enough to eat. In March 2021, DCFS unfounded the investigation. The second report alleged medical neglect to the teen's 15-year-old sister because the school reported that mother did not follow through with a Screening Assessment and Support Services (SASS) evaluation. The mother told the CPI she contacted SASS, but they did not come to the home. The sister admitted to mental health concerns in the past year but denied present concerns and felt safe in the home. The 15-year-old's physician stated the mother demonstrated appropriate concern and difficulties with scheduling appointments were due to the COVID pandemic. In February 2021, DCFS unfounded the investigation. In June 2021, DCFS received a report that the teen's 15-year-old sister had not received care for her diabetes since 2019, did not have a

primary care physician, had not had her asthma medication refilled, and the sister refused to attend school or participate with mental health services. The CPI met with the family; the sister reported she had her asthma medication, and her school social worker was trying to locate a therapeutic school for her. The mother reported difficulty getting the sister to appointments because of her own medical issues, and the sister sometimes refused to attend her appointments. The 9-year-old sister reported no concerns and appeared healthy. At the time of the investigation, the teen was living with a friend, but had frequent contact with the mother. The investigation remained pending at the time of the teen's death. DCFS later indicated the investigation for medical neglect to the teen's 15-year-old sister. The family's intact family services case opened in July 2021, to assist the family with managing the sister's diabetes. The family continued to receive intact family services after the teen's death.

Child No. 118	**DOB: 02/2020**	**DOD: 09/2021**	**Natural**
Age at death:	18 months		
Cause of death:	Complications of prematurity		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eighteen-month-old was in the care of a maternal relative when she began having trouble breathing. The relative reported the toddler and her five siblings had been in her care for four days. The toddler had a fever when she came to the home, which the mother attributed to teething. The toddler continued to worsen over the coming days, and the relative called 911 when the child had distressed breathing. The toddler was transported to the hospital, where she died. The toddler had been born prematurely, at 25 weeks gestation, and had longstanding medical conditions. DCFS investigated the toddler's death and unfounded the maternal relative for death by abuse.

Reason for Review: In August 2020, DCFS received a report that the toddler's 8-year-old sister disclosed that a family friend had exposed himself to her and made her remove her clothing. The mother reported the family friend was a former paramour with whom she remained friends, and he did not live in the home but had recently babysat. The mother contacted police, scheduled a forensic interview for the sister, and stated she would not allow the former paramour to see the children. In a forensic interview, the 8-year-old reported she was not scared of anyone except for the former paramour. The family missed their additional forensic interviews and the mother had not responded to attempts to contact her. The former paramour was a registered sex offender who was non-compliant with weekly reports. His address in the sex offender registry was listed as "homeless," and the CPI was unable to locate him for an interview. Police suspended their criminal investigation. In October 2020, DCFS unfounded the former paramour for sexual exploitation and substantial risk of sexual abuse due to insufficient evidence and non-cooperative witnesses.

Child No. 119	**DOB: 07/2021**	**DOD: 09/2021**	**Natural**
Age at death:	2 months		
Cause of death:	Bacterial bronchopneumonia of the lungs		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Two-month-old was found unresponsive at home by his mother, who called 911. The infant was transported to the hospital by ambulance, where he was pronounced deceased. DCFS investigated the infant's death and unfounded the mother for death by neglect.

Reason for Review: In August 2021, DCFS received a report that the family's home was uninhabitable, and the infant and his siblings were running around unclothed. The CPI met with the mother and observed the home to be clean and appropriate, with safe sleeping arrangements, working utilities,

and food. The CPI did not see the children before the infant died. DCFS later unfounded the investigation because the home was found to be clean and orderly.

Child No. 120	DOB: 08/2021	DOD: 10/2021	Natural
Age at death:	2 months		
Cause of death:	Bronchopneumonia and myocarditis due to systemic viral infection		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Two-month-old was found not breathing around 7:30am by his mother, who called 911 and attempted CPR. The mother stated she had last seen the infant alive around midnight, when she fed him and placed him on his back in a sleeper in the parents' bed. The sleeper had a hard barrier and was observed with two bottles, a pacifier, and blankets inside. First responders noted it appeared the infant had been deceased for a while. In the three weeks before his death, the infant was seen by his pediatrician, who recommended adding formula; he was brought to the hospital for difficulty breathing, where he was diagnosed with a viral upper respiratory tract infection; and he received immunizations. DCFS investigated the infant's death and unfounded his parents for death by neglect.

Reason for Review: In November 2020, DCFS received a report that the infant's maternal aunt left her three children, the infant's cousins, in the care of the infant's parents while she went out of state. The cousins were then between the ages of 4 months and 2 years. The reporter stated it was unknown when the maternal aunt would return, the maternal aunt knew the infant's father was a registered sex offender, the home was dirty with animal feces and urine, there was marijuana within the cousins' reach, and the then 4-month-old cousin had not seen a doctor since birth. Three days after the report, following two good faith attempts to see the family, the CPI met with the maternal aunt at her home and observed the children. The maternal aunt stated the infant's mother had previously lived with her but had to move out when she became involved with the infant's father. She stated the infant's mother informed her the father came to the front door to drop off money, but he did not come inside the home. The CPI completed the home safety checklist and marked the cousins as safe. In August 2021, the infant was born. That month, the CPI spoke with staff in the office of the cousins' pediatrician, who reported the then 13-month-old cousin had not been seen since July 2020, but the then 2-year-old and 3-year-old cousins had been seen in April 2021 for school physicals, and the pediatrician reported no concerns. Five days later, the CPI met with the infant's mother for the first time. The mother reported that at the time of the incident in November 2020, the infant's father, a registered sex offender, did not live with her because the home was within 500 feet of a school. She reported the father had dropped off money and looked for something in the shed but did not have access to the children at any time. She reported no plans to watch the infant's cousins in the future. The mother stated the father was on probation and could not have unsupervised contact with children under 18, but his probation officer and attorney were aware of the infant's birth and had not imposed any limitations. The CPI spoke with the father, who confirmed the mother's report. In September 2021, DCFS unfounded the parents for substantial risk of sexual abuse by neglect.

Child No. 121	DOB: 09/2005	DOD: 10/2021	Natural
Age at death:	16 years		
Cause of death:	Pulmonary hemorrhage due to pulmonary infection due to hemophagocytic lymphohistiocytosis		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old died at the hospital, where he had been admitted five weeks earlier for ongoing medical issues. The teen had been born with a congenital heart defect and had received two heart transplants during his life. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In September 2021, DCFS received a report that the teen had been admitted to the hospital, and it was reported that the teen had witnessed his father punching his mother in the face, causing her teeth to fall out. The CPI attempted to interview the teen at the hospital, but staff reported the teen was sedated and resting. The father was present at the hospital and denied the allegations. The CPI later met with the mother, who reported she moved into a new home with the teen's 13-year-old brother and reported she had been in the hospital for medical and mental health issues at the same time the teen was hospitalized. She denied the allegations but admitted to past domestic violence issues and stated she no longer lived with the father. The mother declined intact family services. The teen's brother stated he had never witnessed domestic violence between his parents, the father did not live with them, and he felt safe at home. The teen's maternal aunt was at the home and reported she was staying with the family to help the mother. She confirmed the father no longer lived with the family, and the parents were no longer in a relationship. She stated she spoke to hospital staff about the father abusing the mother because she was concerned for the mother's safety. The CPI screened the case with the State's Attorney because the mother declined intact family services. The State's Attorney declined to file for court-ordered services. In January 2022, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 122	**DOB: 11/2018**	**DOD: 10/2021**	**Natural**
Age at death:	2 years		
Cause of death:	Hypoxic ischemic encephalopathy due to hypovolemic and septic shock due to SAM syndrome		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old was vomiting, so his mother gave him Pedialyte and took him to the doctor, who instructed the mother to take him to the hospital. The mother reported they went home, the toddler collapsed, the mother began CPR, and called for an ambulance. The toddler was transported to the hospital, where he went into cardiac arrest; he was transferred to a children's hospital where a CT scan showed brain swelling. The toddler died three days later. The toddler had SAM syndrome, a rare and life-threatening genetic condition. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: In February 2021, DCFS received a report that the toddler received nursing care during the day but was left alone in the basement and not receiving proper care at night, including feedings, application of ointment every two hours per physician's orders, and diaper changes. The toddler's mother denied the allegations and provided a letter from the toddler's medical specialist that stated the family was following the toddler's care and was experiencing harassment from the nursing agency. In March 2021, DCFS received a similar report. In April 2021, a supervisor at the nursing agency reported the agency had no concerns about the family, and a new nurse had been assigned to the family. The toddler's genetic specialist and primary care physician reported no concerns about the toddler's care. In April 2021, DCFS unfounded the investigation for medical neglect and inadequate supervision. In September 2021, DCFS received a report that the toddler's crib was soiled with dried vomit, and the toddler was dirty and was not receiving appropriate care when nurses were not in the home. The CPI observed the toddler and his crib to be clean. The mother reported she was trained to and did care for her son, and the family had nurses in the home nearly 24 hours per day. The investigation remained pending at the time of the toddler's death. An in-home nurse who took care of the child in the days before his death reported his needs were being met and she had no concerns about his care. DCFS later unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by neglect and environmental neglect.

Child No. 123	DOB: 10/2021	DOD: 10/2021	Natural
Age at death:	3 days		
Cause of death:	Cardiogenic shock due to severe pulmonary hypertension		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn died at the hospital three days after he was born by emergency c-section at 34 weeks gestation. An ultrasound had identified birth defects that required immediate intervention. DCFS did not investigate the newborn's death.

Reason for Review: In September 2020, DCFS received a report that the newborn's then 4-year-old maternal half-sister was being sexually abused by her father's wife. The sister made no disclosure during a forensic interview, her pediatrician reported no concerns about her care in her father's home, and her therapist stated she had not made any outcries during individual therapy. Law enforcement reported the mother and the sister's father had on-going issues and frequently made reports against each other. In November 2020, DCFS unfounded the investigation for substantial risk of sexual abuse and substantial risk of physical injury/environment injurious to health and welfare by abuse. That same month DCFS received a report the mother's home had holes in the floor and broken windows, and there was domestic violence between the mother and her paramour. The newborn's sister appeared healthy, clean, and unharmed. The mother told the CPI the sister lived with her during the week and with her father on weekends. The CPI did not observe any broken windows but did observe an area in the living room where a rug covered a dip in the floor. The mother stated the sister knew to walk around the area, and her paramour stated they tried to get assistance from a community program to repair the floor, but they did not qualify. The mother and paramour planned to fix the floor that weekend and five days later, sent the CPI photos of the repairs. In January 2021, the mother reported she and the sister moved in with the sister's father. The home appeared safe and appropriate. In January 2021, DCFS unfounded the investigation for inadequate shelter.

Child No. 124	DOB: 01/2020	DOD: 11/2021	Natural
Age at death:	21 months		
Cause of death:	Respiratory failure due to congenital heart disease		
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 pronounced deceased at the hospital from medical complications. Her mother called 911 after she had started coughing and turned blue during a bath. The toddler had been diagnosed with congenital heart disease and heteroataxy syndrome, which affects the major organs. She had undergone at least six heart surgeries. DCFS did not investigate the toddler's death.

Reason for Review: In February 2021, DCFS received a report that the toddler was brought to the hospital by ambulance for fever and difficulty breathing. The child required use of a trach and feeding tube. Medical staff attempted to treat her and requested an ambulance to transfer her to a children's hospital, but her parents refused the transport and drove her to the children's hospital in their own car. The toddler was admitted to the PICU for stabilization and observation. The toddler's cardiologist reported no concerns for medical neglect because the toddler's mother had been invested in the toddler's care since birth, had the necessary training to care for the toddler's complex care, and had kept all appointments. The mother stated that on the day of the incident, EMTs transported her to the nearest hospital, despite her request that she be transported to the children's hospital, so when they were told she would need to be transported to the children's hospital, she became upset. Medical staff involved in the child's care stated the mother had not refused treatment as she sought medical care immediately and knew that the first hospital the child was transported to was not equipped to treat her. Hospital staff informed the CPI that the toddler would need wrap-around services after discharge and a nursing referral was completed. DCFS unfounded the investigation against the mother for medical neglect.

Child No. 125	DOB: 07/2018	DOD: 11/2021	Natural
Age at death:	3 years		
Cause of death:	Viral pneumonia, significant contributing condition of multiple congenital anomalies		
Reason for review:	Open intact family services case and two pending child protection investigations at the time of death; one 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 a prone position, with her trach not attached, by her home health nurse. The toddler was transported to the hospital, where she was pronounced deceased. She had an extensive medical history, including Treacher-Collins syndrome, a rare genetic disorder resulting in distinctive abnormalities of the head and face; low weight gain; chronic respiratory failure; cleft palate; hearing loss in both ears and anophthalmia, the absence of one or both eyes. She required a trach due to an undersized lower jaw and a g-tube for feeding. At the time of her death, she had an upper respiratory infection for which she was receiving oxygen therapy. Her mother reported she heard noises coming from the toddler's room approximately an hour before she was found unresponsive, but the noises were not uncommon for her. The mother believed the toddler had gone back to sleep, and when she checked on her 30 minutes later, the toddler appeared to be sleeping. The autopsy report noted the toddler showed no signs of abuse or neglect. DCFS investigated the toddler's death and unfounded her parents for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect based on the findings of the autopsy.

Reason for Review: In September 2020, DCFS opened an intact family services case for the family during an investigation that was later indicated for medical neglect to the toddler. In November 2020, the intact worker documented the toddler was in a skilled nursing facility following surgery and could not return home until nursing services were in place. The Division of Specialized Care for Children (DSCC) reported difficulty securing nursing services due to an ongoing roach infestation in the home, because nurses were concerned about roaches getting into her trach. In January 2021, nursing services were secured, and the toddler was discharged home. In March 2021, DCFS received a report that the toddler had missed multiple appointments, and the toddler's g-tube had fallen out numerous times. During the investigation, the toddler missed additional appointments and weight checks. In May 2021, DCFS indicated the parents for medical neglect. In June 2021, the pediatrician reported she knew the toddler had lost weight, so they were working with a specialist to determine the cause, and the mother had become consistent with appointments. During an unannounced home visit, the intact worker found an in-home nurse was not present and learned the assigned nurse refused to return to the home because of an ongoing roach infestation. The intact worker continued making weekly visits to the home and assured nursing services were reinstated. The family had also been offered housing services, counseling, and parenting classes, but the mother did not engage in services. In October 2021, the mother reported she no longer wanted intact services. The next day, DCFS received a report that the toddler's 1-year-old brother had bruises under both eyes, across the bridge of his nose, and on his forehead. The mother stated the bruises were from the toddler's 2-year-old brother pinching him and falling from a bed. The mother stated she did not report the bruises or seek medical care because she did not think it was needed. The CPI advised the mother to take the 1-year-old to the hospital that day, and his CT scan was negative for fractures. DCFS determined the intact worker would continue weekly visits as a result of the new investigation. The investigation remained pending at the time of the toddler's death. The investigation was later indicated for inadequate supervision and unfounded for cuts, bruises, welts, abrasions, and oral injuries by abuse. Three days before the child's death, DCFS received a report that the toddler's 1-year-old brother had a large, plum-sized bruise on his right upper arm and three pea-sized bruises on his left hip. The reporter stated the child did not have the bruises a few days before. The day before the toddler's death, the brother was taken for a medical exam, and medical staff did not have concerns about the bruises but noted the large bruise was consistent with a bite mark. The mother provided incident reports from the brother's daycare

and maintained she did not know how the brother received the bite mark. The toddler's 4-year-old sister reported no concerns of her brothers being intentionally injured. The investigation remained pending at the time of the toddler's death, and was later unfounded for cuts, bruises, welts, abrasions, and oral injuries by abuse.

Child No. 126	**DOB: 05/2014**	**DOD: 11/2021**	**Natural**
Age at death:	7 years		
Cause of death:	Escherichia coli sepsis due to diabetic ketoacidosis – new onset diabetes due to large bowel necrosis		
Reason for review:	Child was a youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-year-old was removed from life support after complications from type 1 diabetes. The child had been diagnosed with diabetes just three days earlier when his relative foster mother brought him to urgent care because of weight loss and lethargy. He was transferred to the hospital, developed e coli, and became septic. The child went into cardiac arrest after emergency surgery to relieve the pressure from his enlarged stomach: he was revived and intubated. His condition deteriorated, and he had no brain activity. He was removed from life support at his family's request. DCFS did not investigate the child's death.

Reason for Review: In October 2020, DCFS received a report that the child had bruising on the left side of his jaw, abrasions on his right cheek and neck, and a hematoma on his forehead. The child stated his stepfather kicked him and hit him with a metal cooking spoon as punishment. DCFS took protective custody of the child that day. DCFS indicated the child's mother and stepfather for substantial risk of physical injury/environment injurious to health and welfare by neglect to the child and his 6-month-old brother. The stepfather was also indicated for cuts, bruises, welts, abrasions, and oral injuries by abuse to the child. The children were placed in a licensed foster home with their maternal aunt. The stepfather was criminally charged with aggravated battery to the child. Recommended services included individual therapy, family therapy, parenting education, and parenting coaching. The caseworker documented the child's parents participated in services and made satisfactory progress towards the goal of return home, but they continued to deny the allegations. Two weeks before the child died, a clinical staffing took place because the mother remained in a relationship with the stepfather.

Child No. 127	**DOB: 08/2019**	**DOD: 11/2021**	**Natural**
Age at death:	2 years		
Cause of death:	COVID 19 acute respiratory failure; significant contributing conditions of epilepsy, SPTAN 1 mutation, congenital hypotonia, microcephaly		
Reason for review:	Pending child protection investigation at time of child's death; closed intact case and unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old medically complex child died at the hospital from COVID pneumonia. The day before her death, the mother brought the toddler to the hospital, and she was admitted to the PICU. The toddler had been born with a rare congenital disorder, SPTAN-1 mutation; congenital hypotonia; microcephaly and intractable epilepsy. She required a feeding tube and oxygen at night for obstructive sleep apnea. In the fall of 2021, her condition deteriorated, and her parents began palliative care and signed a DNR (do not resuscitate) order. DCFS did not investigate the toddler's death.

Reason for Review: Following reports of domestic violence and substance use, an intact case was opened in June 2020. In December 2020, DCFS received a report that the toddler's 15-year-old half-sister disclosed that the mother's former paramour sexually molested her when she was 5 years old. Police

reported attempts to interview the half-sister, but she did not cooperate. The CPI observed the former paramour's children and assessed them to be safe with their paternal grandparents, with whom they lived, and the former paramour agreed to stay away from the home during the investigation. The mother also agreed to keep the children in her care away from the former paramour and stated the toddler's then 9-year-old half-brother, who was the former paramour's child, was the only child who saw him regularly. During an interview at the Children's Advocacy Center, the 15-year-old half-sister reported that 10 years earlier, the former paramour lifted her shirt and rubbed her legs and stomach while she was sleeping. She denied any penetration. The 9-year-old half-brother denied anyone ever touched him inappropriately. In April 2021, DCFS unfounded the investigation for sexual molestation and substantial risk of sexual abuse. In March 2021, after the parents had been uncooperative with services, a court petition was filed, and the parents were court ordered to cooperate with services. The mother reported plans to reapply for in-home nursing care for the toddler. The toddler had been hospitalized multiple times for viral infections, continued to have difficulty breathing, and her seizures were increasing in frequency and duration. She was monitored by her primary care physician as well as specialists. In April 2021, the toddler's 15-year-old half-sister was psychiatrically hospitalized for two weeks after refusing to participate in outpatient mental health services. In May 2021, DCFS received a report that the 15-year-old half-sister stated she did not feel safe at home. The other children reported feeling safe at home and stated the parents disciplined them by removing electronics and grounding them. The toddler was observed to be free of visible concerns. The investigation was unfounded. In June 2021, the toddler began receiving 56 hours of nursing services per week. That month, the father completed a domestic violence assessment and began classes. In October 2021, the mother had successfully completed domestic violence services. The court ordered the case closed. The day before the toddler died, DCFS received a report that the toddler's father locked the 15-year-old half-sister out of the home around 2:00am the night before, so she walked to a gas station to call her grandmother. The half-sister stated the father was the only adult home at the time because the mother was at the hospital with the toddler. The investigation remained pending at the time of the toddler's death. DCFS later unfounded the investigation for inadequate supervision.

Child No. 128	**DOB: 07/2019**	**DOD: 11/2021**	**Natural**
Age at death:	2 years		
Cause of death:	Complications of Williams syndrome		
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, with his trach disconnected, after his ventilator alarm began ringing. His parents called 911 and began CPR, and he was transported to the hospital by ambulance, where he was pronounced deceased. The toddler had multiple medical diagnoses, including Williams syndrome, a rare genetic disorder that includes growth delays, cardiac defects, and musculoskeletal defects; aortic valve stenosis, a condition that blocks blood flow in the heart; and liver issues. He had undergone several cardiac surgeries and required a ventilator and feeding through a g- tube. DCFS did not investigate the toddler's death.

Reason for Review: In December 2020, DCFS received a report that the toddler had been admitted to the hospital three days earlier and had unexplained bruising that looked like handprints on his torso, legs, back, spine, and abdomen. The hospital later determined the bruising was due to a blood platelet abnormality, and they did not suspect abuse. Doctors discharged the toddler to his parents. The in-home nursing service reported working with the family since the toddler's birth and had no concerns of maltreatment. DCFS completed a nursing referral. In March 2021, DCFS unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse.

Child No. 129	DOB: 10/2013	DOD: 11/2021	Natural
Age at death:	8 years		
Cause of death:	Renal failure due to resolving peritoneal abscess as a consequence of peritoneal dialysis dependent end state renal disease		
Reason for review:	Child was a youth in care within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-year-old was found unresponsive and not breathing in his bedroom while undergoing at-home dialysis. The child had been diagnosed with kidney failure at birth. The child's mother called 911 and the child was transported by ambulance to the hospital, where he was pronounced deceased. The coroner reported the child's dialysis records showed his mother used the dialysis machine correctly. DCFS investigated the child's death and unfounded his mother for death by neglect.

Reason for Review: The child came into DCFS care in 2019. In July 2020, the court returned the child to his mother's care, but his DCFS case remained open. His caseworker continued weekly visits, and the agency's nurse continued monthly visits. In January 2021, the child had surgery to close an opening in his neck. In June 2021, he had a consultation for kidney transplant eligibility. In August 2021, the court closed the family's case and returned the child's guardianship to his mother.

Child No. 130	DOB: 04/2021	DOD: 11/2021	Natural
Age at death:	7 months		
Cause of death:	Undetermined natural causes		
Reason for review:	Open intact family services case at time of child's death; one indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-month-old began wheezing and gasping for air, so his mother called 911 and he was transported to the hospital, where he was pronounced deceased. The day before his death, the mother brought him to the hospital because of congestion and labored breathing. The baby was diagnosed with pneumonia, provided antibiotics, and discharged that evening. DCFS did not investigate the infant's death.

Reason for Review: In April 2021, DCFS received a report that the infant and his mother tested positive for amphetamines and marijuana when the infant was born. The mother admitted to taking Adderall (amphetamine/dextroamphetamine) that was not prescribed to her, and she reported she had mental health issues as a teenager. DCFS placed the infant and the 3-year-old sister with a maternal aunt under a safety plan. The mother engaged with a substance use treatment program and declined intact family services. DCFS indicated the mother for substance misuse by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect. In August 2021, police contacted DCFS when the infant's father reported the mother had left the infant in a carrier outside his apartment building, and he could not care for the baby. In addition, the mother told him she had thoughts of harming herself and the infant. The mother told police she did not have transportation to pick up the infant. DCFS took separate reports on each parent. The father told the CPI he could care for the baby for the next few days and declined services. The mother reported the father knew she was bringing the infant to his home and handed the infant directly to him. The mother admitted to telling the father she wanted to harm herself but denied she said she would harm the infant. The mother completed a mental health assessment and began counseling and medication management. The family's primary care physician reported no concerns with the mother's ability to care for the children and reported the infant was meeting his developmental milestones. The mother reported no plans to remove the 3-year-old from her maternal aunt's care. DCFS unfounded the parents for inadequate supervision, and the mother was also unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect. In November 2021, DCFS opened an intact family services case for the mother. The intact worker noted the mother was already receiving counseling services and medication management but needed services for daycare, housing assistance, and employment resources. The intact worker observed the child to be congested, and the

mother reported that she would bring him to the doctor if his symptoms persisted. The intact case remained open after the infant's death.

Child No. 131	**DOB: 09/2018**	**DOD: 11/2021**	**Natural**
Age at death:	3 years		
Cause of death:	Complications of cardiomyopathy in the setting of known familiar MYBPC3 mutation		
Reason for review:	Child was a youth in care; one indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old was transported to the hospital in respiratory distress. The toddler had congestion, vomiting, and diarrhea for a few days. He had been brought to a hospital clinic before being transferred to the hospital, then he was airlifted to a children's hospital. The next morning, the hospital removed life support and he died. The toddler's paternal grandmother, with whom he was placed, reported that the day before he died, she took him to a wellness appointment with his pediatrician. She stated the clinic would not see the toddler because he had COVID symptoms. The toddler was taken to the hospital, where he tested negative for COVID and tested negative for all substances except those administered by the hospital. DCFS investigated the toddler's death and unfounded the investigation for death by neglect.

Reason for Review: In February 2021, DCFS received a report that the toddler's parents, who had a history of drug use, injected heroin in the presence of the toddler and drove intoxicated with the toddler in the car. The CPI met with the family at the home of the toddler's maternal grandmother. The parents did not appear intoxicated, and the CPI did not observe signs of intravenous drug use. The parents reported they had maintained their sobriety and participated in a suboxone treatment program. The toddler was assessed as safe in the home. The toddler's paternal grandmother denied any concerns that the parents had relapsed and used drugs. The pediatrician reported three missed new patient appointments. In May 2021, the CPI again met with the family at the maternal grandmother's home, observed the parents bathe and dress the toddler, and noted they appeared coherent and appropriate. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. In July 2021, DCFS received a report that law enforcement responded to a call that the toddler and his parents were sleeping in a car in a parking lot. Officers found syringes, heroin, a methamphetamine pipe, and multiple prescription drugs in the car. They noted the father and the toddler were asleep in the back seat, but the mother did not appear intoxicated. Police arrested the father. The CPI made multiple attempts to see the family at different addresses before locating the family at the maternal grandmother's home. The mother initially denied knowledge of the father's drug use, then admitted she knew he was intoxicated and had drugs and paraphernalia. The father reported he self-medicated due to severe pain and had relapsed. Both parents agreed to participate in intact family services. The mother admitted to smoking marijuana daily and using drugs, but stated her last use was the month prior. The father admitted to using methamphetamine one week earlier. In October 2021, the father was arrested after he was again observed asleep in a car with the mother and toddler. DCFS took protective custody of the toddler. The maternal grandmother reported the family lived with her and denied knowledge that the parents were using drugs. The toddler was placed with his paternal grandmother. DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. Recommended services included substance use treatment, counseling, and employment services. The parents reported they were on the waitlist to begin substance use treatment and counseling. The toddler was observed to be healthy and bonded to his paternal grandmother and parents. One month after the placement case opened, the toddler died.

Child No. 132	DOB: 09/2021	DOD: 11/2021	Natural
Age at death:	2 months		
Cause of death:	Cardio respiratory failure due to Ebsteins anomaly [sic]		
Reason for review:	Open placement case and pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old died at the hospital where he had been since birth. The infant had Ebsteins anomaly, a congenital heart defect and required hospitalization in the NICU, multiple surgeries, and a feeding tube. The infant was placed on an extracorporeal membrane oxygenation machine to support his heart and lungs and was on a list for an organ transplant when his organs began to fail. DCFS did not investigate the infant's death.

Reason for Review: In 2020, the infant's siblings, then ages 5 months, 4 years, 12 years, and 15 years, came into care. The children were initially placed together with their maternal grandmother, but later moved to separate relative and fictive kin homes. The mother participated in visits with the children, completed parenting classes and anger management classes, attended therapy, attended psychiatric assessments and services, and attended domestic violence services. In September 2021, DCFS opened a new investigation against the mother following the infant's birth due to her history with DCFS. Following the infant's death, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 133	DOB: 04/2021	DOD: 12/2021	Natural
Age at death:	7 months		
Cause of death:	Right heart failure and pulmonary hypertension due to secundum atrial septal defect; significant contributing conditions of bronchopneumonia, mosaic Down syndrome, and failure to thrive		
Reason for review:	Two pending child protection investigations at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-month-old was found unresponsive by her mother. Emergency services transported the infant to the hospital, where she was pronounced deceased. The infant's medical issues included mosaic Down syndrome, trisomy 21, Hirschsprung's disease, and hypothyroidism, and she required a feeding tube. The mother reported she fell asleep with the infant for approximately 30 minutes, and when she awoke, she found the infant on her back, unresponsive. The mother reported she had been living at a hotel with the infant and her 2-year-old for approximately one week due to domestic violence, and the older siblings were with a relative. DCFS investigated the infant's death and unfounded her mother for death by neglect and medical neglect.

Reason for Review: In October 2021, DCFS received a report that police responded to the family home for a domestic violence incident. The reporter stated the infant's father attempted to strangle the mother and the infant's 12-year-old maternal half-brother, and both received medical care for injuries. Police arrested the father. The mother reported the incident was the first time he physically assaulted her or the children. The 12-year-old reported he intervened when he observed the infant's father hurting his mother, and he believed both adults sometimes drank alcohol. The 8-year-old brother also witnessed the altercation. The CPI observed the infant and his 2-year-old sister to be clean and appropriate. The children all reported they felt safe with their mother. The mother obtained an order of protection against the infant's father. The father denied physically assaulting the mother and children. The mother declined intact family services and stated she and her children planned to move in with her mother. One week after the first investigation opened, DCFS received a report that the infant was losing weight, and doctors had concerns about failure to thrive. The infant had medical complexities. The mother and the infant's meconium both tested positive for marijuana at the infant's birth. The infant had been discharged from the NICU in September 2021, approximately five months after her birth, with arrangements for home health care. The

reporter stated the mother had missed the infant's last three weight checks and other appointments. The reporter stated the mother had been trained on feeding the infant but admitted to home health staff that she had missed feedings. The CPI observed the mother's notebook documenting the infant's appointments and feedings, and the mother secured medical transportation for the infant's upcoming appointments. The infant and her three siblings were observed to be well cared for and the verbal children reported they felt safe at home. The investigation remained pending at the time of the infant's death. DCFS indicated the father for substantial risk of physical injury/environment injurious to health and welfare by abuse and neglect. The mother was unfounded for medical neglect.

Child No. 134	**DOB: 12/2021**	**DOD: 12/2021**	**Natural**
Age at death:	0 days		
Cause of death:	Extreme prematurity		
Reason for review:	Open intact family services case at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn and his twin were born at the hospital at 25 weeks gestation. The newborn died approximately two hours after his birth. The twin died in the womb and was considered a stillbirth. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: The newborn's 18-year-old mother lived with her mother, the newborn's maternal grandmother. The mother's seven siblings and the grandmother's paramour also lived in the home. In November 2020, DCFS opened an investigation against the grandmother, who had been arrested for being asleep at the wheel of a car, had a high blood alcohol level, lacked a valid driver's license, and was pregnant. In January 2021, DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by neglect because no children were with her. However, DCFS opened an intact family services case for the family due to the investigation. The grandmother's paramour moved out of the home after the intact case opened. The grandmother was referred for and began substance use treatment. The intact worker provided cribs and baby equipment to the family, helped enroll the mother's siblings, who were under the age of 5, in daycare and Head Start, and referred the family for community-based services for housing advocacy and transportation assistance. The family also participated in family counseling, and the grandmother participated in parenting classes. In September 2021, the intact worker learned the newborn's then 17-year-old mother was pregnant and had applied for housing in the same complex where the grandmother lived. In November 2021, the grandmother completed substance use services. In December 2021, the grandmother requested that DCFS close the intact family services case. The intact case remained open at the time of the newborn's birth and death.

Child No. 135	**DOB: 11/2021**	**DOD: 12/2021**	**Natural**
Age at death:	7 weeks		
Cause of death:	Viral pneumonia with meningitis		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-week-old was found unresponsive after co-sleeping with his mother. The mother called 911 and began CPR. The infant was transported to the hospital, where he was pronounced deceased. At the time of his death, the infant's 3-year-old, 5-year-old, and 7-year-old siblings were with an aunt, and their father was in the hospital with a collapsed lung. The mother reported the infant had a cough in the days prior to his death but was not on any medications or under a doctor's care. The mother reported the infant's 3-year-old and 7-year-old siblings had been diagnosed with a respiratory infection a week prior. DCFS investigated the infant's death and unfounded the mother for death by neglect based on the autopsy findings.

Reason for Review: In February 2021, DCFS received a report of excessive screaming and crying coming from the family's home, the children were left in the car alone for long stretches of time, the children wore inadequate clothing for the weather, and the parents used substances. The mother denied the allegations. She stated there was one incident when the oldest child ran around the building, but his behavior was addressed afterward. The father of the infant's then 5-year-old and 6-year-old half-siblings denied any concerns about the mother's care of the children. In March 2021, DCFS unfounded the investigation for inadequate supervision.

Child No. 136	**DOB: 07/2018**	**DOD: 01/2022**	**Natural**
Age at death:	3 years		
Cause of death:	Cerebral palsy with seizure disorder		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old was found unresponsive at home by his paternal aunt's paramour. The paramour called 911 and followed the dispatcher's directions until first responders arrived. The toddler was transported by ambulance to the hospital, where he was later pronounced deceased. At the time of the incident, the toddler, his 6-year-old and 7-year-old brothers, and his 7-year-old cousin were in the care of the paramour. The toddler's father and paternal aunt took the mother to work approximately 30 minutes earlier. The toddler had encephalopathy, spastic quadriplegic cerebral palsy, and a seizure disorder, and he required a trach. Medical staff noted he lived longer than expected with his conditions. DCFS investigated the toddler's death and unfounded the paramour for death by neglect.

Reason for Review: In January 2021, DCFS received a report that the toddler's then 5-year-old brother had lost weight and asked for extra food at school, the toddler's then 7-year-old brother lacked a winter coat and had poor hygiene, the family lived in a one-bedroom apartment with six adults and four children, and the 5-year-old brother reported he slept in a closet with adults. The mother told the CPI the family had enough food, the adults took turns cooking meals and doing laundry, and the children slept on beds, not in a closet. The toddler's brothers were observed to be wearing clean clothes, and they confirmed they slept on mattresses. The home was observed to have adequate food and no safety concerns. DCFS unfounded the investigation for inadequate food, inadequate clothing, and environmental neglect. In October 2021, DCFS received a report that the toddler's then 8-year-old brother had bruises and scratches on his face and disclosed his father had injured him. The CPI observed the injuries; family members stated the brother had been injured by the family dog and all household members denied witnessing the father injure the brother. The 8-year-old brother stated his father did not hit him, and he was not afraid of his father. In December 2021, DCFS unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse.

Child No. 137	**DOB: 07/2012**	**DOD: 01/2022**	**Natural**
Age at death:	9 years		
Cause of death:	Chronic seizure disorder (epilepsy)		
Reason for review:	Child was a youth in care within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-year-old was found with blood and foam coming out of her mouth. Her father's paramour called 911 and began CPR. The child was transported to the hospital by ambulance, where she was pronounced deceased. The child had a history of seizures since 2016. She had been taken to the emergency room seven times and was admitted to the hospital twice, but none of her earlier seizures were deemed life threatening. Her paternal grandmother, who was her adoptive mother, reported she sometimes watched the child to assure she took her prescribed medication to manage her seizures, as the child did not like it. She stated the child had not had a seizure in over seven months. The child had last been seen by

her neurologist November 2021, who noted her medication levels were appropriate. Medical staff noted that missing one or two doses of the medication could cause seizures. The child had been staying with the paramour since the day before her death due to her paternal grandmother's work schedule, and the grandmother confirmed the child packed her medication. The paramour lived with her 6-year-old and 12-year-old children. Her 12-year-old son later alerted her that he attempted to wake the child to play and found her bleeding. DCFS investigated the child's death and unfounded the paramour for death by abuse.

Reason for Review: The child came into care in 2016, at 4 years old, along with her twin sister and then 2-year-old brother. In 2020, the children were placed with their paternal grandmother. In the year before the child's death, the child and her twin remained with their paternal grandmother. The child's brother had been placed with another relative. In April 2021, the paternal grandmother adopted the child and her twin sister, and their placement case was closed.

Child No. 138	DOB: 04/2009	DOD: 01/2022	Natural
Age at death:	12 years		
Cause of death:	Small bowel necrosis due to clostridium perfringens bacteremia		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-year-old was found unresponsive, cold, and stiff. Paramedics responded to a 911 call and found her family performing CPR; paramedics were unable to continue CPR because rigor mortis had begun to set in. The parents reported they had last seen her alive approximately two hours earlier. She had been treated at the hospital a few days prior for possible food poisoning and was discharged the same day with an antibiotic and anti-nausea medication. DCFS did not investigate the child's death.

Reason for Review: In December 2021, DCFS received a report that the child's 17-year-old sister was assaulted by her maternal uncle, who was intoxicated, and the sister sustained knots on her head. The child stated the uncle also hit her, but she did not sustain any injuries. The reporter stated the sister disclosed wanting to harm herself. Police arrested the uncle for domestic battery to the sister. The uncle did not live in the home. The mother was at work when the incident occurred and stated the uncle went to the home to bring groceries and found the sister and her friend smoking marijuana. The child stated her uncle started arguing with her sister, her sister and uncle were both hitting each other during the altercation. The child said she had never seen her uncle hit her sister before. The mother stated the sister frequently ran away from home and did not attend school. In January 2022, DCFS unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse and substantial risk of physical injury/environment injurious to health and welfare by abuse because the uncle did not live in the home and was not in a caretaking role for the children and was therefore an ineligible perpetrator.

Child No. 139	DOB: 05/2020	DOD: 02/2022	Natural
Age at death:	20 months		
Cause of death:	Asphyxia due to febrile-related seizure disorder		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Twenty-month-old was found unresponsive in his crib. The foster mother called 911, and he was pronounced deceased at the scene. Hospital staff reported the toddler had a seizure around 9:00pm the evening before but did not require medical attention. The foster mother reported they put the toddler to bed around 10:30pm and checked on him one hour later. DCFS investigated the toddler's death and unfounded the foster mother for death by neglect.

Reason for Review: The toddler came into DCFS care at the age of 4 months. The mother never participated in services, and her whereabouts remained unknown throughout the toddler's involvement. The father completed an inpatient substance use treatment program but was inconsistent in maintaining

sobriety and visiting the child. In January 2022, the toddler's foster mother reported the toddler had a febrile seizure due to respiratory syncytial virus. She stated fevers triggered the toddler's seizures. The toddler was under medical care for the seizures.

Child No. 140	**DOB: 11/2020**	**DOD: 02/2022**	**Natural**
Age at death:	14 months		
Cause of death:	Cerebral palsy and epilepsy; significant contributing conditions of viral upper respiratory tract infection, unsafe sleep environment (bed-sharing with blankets and pillows)		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-month-old was found unresponsive by his mother. The toddler had been diagnosed with cerebral palsy, a seizure disorder, hypotonia, obstructive sleep apnea, and was fed through a g-tube. The mother called 911 and began CPR. The toddler died in the ambulance enroute to the hospital. Shortly before the death, the parents had separated, and the mother had been staying with a friend and the friend's 3-year-old child for five days. The toddler had been sleeping on a nursing pillow in an adult bed with the friend and her 3-year-old child. The mother stated she regularly co-slept with the toddler, and she admitted to drinking the night before, but stated she had not been drunk. The child required oxygen for his sleep apnea, but first responders observed no oxygen tanks. Medical staff reported the toddler would have run out if he had been provided the oxygen as prescribed, and there was no record his oxygen had been refilled. The mother admitted she did not always provide the oxygen, and she did not take all of the toddler's medical equipment when she left the father's home. DCFS investigated the toddler's death and indicated his mother for death by neglect.

Reason for Review: In August 2021, law enforcement responded to a call that the toddler's 2-year-old paternal half-brother was found running around the neighborhood without supervision. At the time of the incident, the brother was in the care of his paternal grandmother, who stated the brother left the home while she was using the bathroom. The family installed a chain lock at the top of the door to prevent additional incidents. DCFS unfounded the paternal grandmother for inadequate supervision. In October 2021, DCFS received a report that the then 10-month-old was admitted to the hospital for seizures, and the father disclosed to hospital staff that the toddler had not taken some of his medication for a few days. Medical staff reported the toddler had missed three appointments in September 2021 and not seen his primary care doctor in over six months. Medical staff told the CPI the parents were observed to be appropriate with the toddler but did not appear to be educated on caring for his medical conditions. They also reported concern that the parents were not feeding him properly through his g-tube, as he was underweight. The mother told the CPI the toddler had been without two of his medications for approximately one month. The mother reported problems with transportation to the neurologist's office, which was three hours away, and they could not find one closer. Also, pandemic restrictions forced them to try and find childcare for their other children while they attended appointments. She stated they also had financial barriers in affording the toddler's specialized formula. The mother reported the toddler had weekly physical and developmental therapy at home. Two weeks after the Hotline report, the toddler was discharged from the hospital. In December 2021, the CPI met with the family at home, observed beds for each of the children, discussed safe sleep with the mother, and observed no marks or bruises on the toddler or his siblings. The mother reported the toddler had been doing well since re-starting his medication. She agreed to intact family services; a referral had been submitted, but the case had not yet opened at the time of the death. The investigation was unfounded for medical neglect.

Child No. 141	DOB: 09/2015	DOD: 02/2022	Natural
Age at death:	6 years		
Cause of death:	Hydrocephalus due to prematurity		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-year-old died in the hospital. The child had a history of hospitalization and a ventriculoperitoneal shunt, a medical device that relieves pressure on the brain due to fluid accumulation. He was pronounced brain dead following a brain surgery completed the month before. DCFS did not investigate the child's death.

Reason for Review: In February 2021, DCFS closed an intact family services case that had been opened in 2020 after the mother was indicated for inadequate supervision and later indicated for medical neglect. During the intact case, the mother completed therapy services, parenting services, and continued to follow up on the child's medical appointments.

Child No. 142	DOB: 11/2021	DOD: 02/2022	Natural
Age at death:	2 months		
Cause of death:	Viral pneumonia with myocarditis		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was found not breathing in his bassinette by his mother. She called 911 and began CPR. The infant was transported to the hospital by ambulance, where he was pronounced deceased. The mother reported she fed the infant approximately two hours earlier and burped him, then he fell back asleep. She reported he had been wheezing in the mornings but would get better through the day. DCFS investigated the infant's death and unfounded his mother for death by neglect.

Reason for Review: In July 2021, DCFS received a report that police were called to the family home for a domestic dispute between the parents, in the presence of the infant's 2-year-old and 3-year-old maternal half-siblings, while the mother was pregnant with the infant. The father left the home after the maternal uncle confronted him. Police located and arrested the father. The children were assessed as safe in the home. Police and hospital staff who treated the mother reported she stated the father struck her in the face, arms, and stomach, but the mother denied these statements to the CPI. The mother declined intact family services. In September 2021, DCFS indicated the mother for substantial risk of physical injury/ environment injurious to health and welfare by neglect.

Child No. 143	DOB: 01/2009	DOD: 02/2022	Natural
Age at death:	13 years		
Cause of death:	Diabetic ketoacidosis		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Thirteen-year-old was transported from his school to the hospital by ambulance in diabetic ketoacidosis. The teen had not been diagnosed with diabetes prior to his death. The teen had last seen his primary care physician in August 2021, who reported the teen's lab results were normal at that time. DCFS did not investigate the teen's death.

Reason for Review: In November 2021, DCFS received a report that the teen disclosed his father hit him with a water hose after he got in trouble at school for punching another student in the stomach. The CPI made a good faith attempt to see the child the next day. Over two months later, in January 2022, the CPI met with the teen at school. The teen stated the incident took place a long time ago and he felt safe at home. He denied his father hit him and stated he was punished with removal of electronics. The reporter

stated they did not observe any injuries on the teen who had never disclosed prior abusive incidents. That day, the CPI spoke with the father, who did not speak English well. The father denied hitting the teen and did not recall the incident. The CPI made plans to call the father back because the language line was not working that day. Five days later, the CPI called the father with the help of the language help line and learned the teen had died. DCFS unfounded the father for cuts, bruises, welts, abrasions, and oral injuries by abuse.

Child No. 144	**DOB: 07/2016**	**DOD: 02/2022**	**Natural**
Age at death:	5 years		
Cause of death:	Vascular malformation of left superior frontal gyrus with rupture into the ventricular system		
Reason for review:	Child returned home within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-year-old was found unresponsive by his mother, who called 911. Law enforcement found the child in his bed with vomit around him. Paramedics began CPR upon arrival and transported the child to the hospital, where he was pronounced deceased. The father had a hereditary disorder that causes multiple abnormalities with blood vessels, and the child's pediatrician had referred the child to a specialist for evaluation. At the time of the child's death, he was on a waitlist to see the specialist. DCFS did not investigate the child's death.

Reason for Review: The family had a placement case dating back to 2019. The child's mother initially began services, disengaged, and re-engaged with services. In March 2021, she was granted unsupervised visits. In September 2021, the children were returned to her care after she completed services. Six months of after-care services were ordered for the mother. The mother agreed to move in with the child's great-grandparents until she could obtain stable housing. The child's caseworker last saw him approximately three weeks before his death via video call. No known medical conditions were listed in the child's case.

Child No. 145	**DOB: 11/2020**	**DOD: 02/2022**	**Natural**
Age at death:	14 months		
Cause of death:	Viral pneumonia with myocarditis and meningitis		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-month-old was found unresponsive in his pack-and-play. The father began CPR and called 911. Law enforcement and emergency medical personnel responded to the home, began life-saving measures, and transported the toddler to the hospital. First responders reported the home was very dirty and the home and the toddler both had a strong odor. Upon arrival at the hospital, the toddler was in full cardiac arrest, and rigor mortis had begun. The father stated he put the toddler and his twin brother to bed around 9:00pm. He gave the twin brother something to drink around midnight, but the toddler did not wake up then. Early in the morning, the father found the toddler face down, slightly stiff, and not moving. The mother stated the father had not allowed her to come into his home after they separated over two months earlier. She reported the toddler's 3-year-old sister had been with the father all week, and the twins had been with him since the day prior to the death. DCFS investigated the toddler's death and unfounded the father for death by neglect but indicated the father for environmental neglect to all three children based on the condition of the home.

Reason for Review: In July 2021, DCFS received reports that the then 7-month-old toddler and his twin brother were very dirty, and their parents brought them to a gathering without bottles, formula, or food for them. When the CPI went to the home to see the children, the father began to yell and denied the CPI entry to the home. The mother yelled that they had plenty of baby food, and the father brought out

five large containers of formula. The parents allowed the CPI to observe the twins and the then 2-year-old sister outside the home. They were clean and free of marks or injuries. A collateral contact reported the parents did bring formula to the gathering, but it was not enough, so they were given Pedialyte. The twins' pediatrician stated they showed good growth and weight gain. The pediatrician confirmed the twins had been seen for all well child checkups, and the parents had not missed or canceled any appointments. DCFS unfounded the investigation for inadequate food and environmental neglect.

Child No. 146	**DOB: 04/2008**	**DOD: 02/2022**	**Natural**
Age at death:	13 years		
Cause of death:	Aspiration pneumonia due to dysplasia and neurological complications		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old, who resided in a skilled nursing facility, was found in cardiac arrest. The teen was transported by ambulance to the hospital, where she died. No life-saving measures were attempted due to an active DNR (do not resuscitate) order. The teen was medically complex and had been diagnosed with cerebral palsy, a seizure disorder, subluxation of her C2 vertebrae, cortical blindness, hip dysplasia, pulmonary collapse, cardiac dysrhythmia, deformed legs, and severe and profound developmental delays. She was nonverbal and immobile. A month prior to her death she was hospitalized for six days with COVID pneumonia. DCFS did not investigate the teen's death.

Reason for Review: In 2010, at 2 years old, the teen came into DCFS care. Since 2015, the teen had resided in a residential care facility and was receiving 24-hour medical care. She was also followed by multiple medical specialists and received physical therapy, occupational therapy, and speech therapy. Her mother was allowed supervised visitation but did not visit with the teen. Her siblings had all been adopted. At the time of her death, the teen's permanency goal was "cannot be provided for in a home environment." Her placement worker made regular in-person and video visits, including a meeting four days before her death during which her medical status was discussed.

Child No. 147	**DOB: 01/2022**	**DOD: 02/2022**	**Natural**
Age at death:	3 weeks		
Cause of death:	Multicystic displastic kidney due to pneumothorax of newborn due to prematurity, birth weight 1,750-1,999 grams, with 33-34 weeks of gestation due to respiratory failure		
Reason for review:	Open placement case and pending child protection investigation at time of child's death; four indicated and four unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Three-week-old died in the hospital. She had been born premature, weighing 4 pounds, and had life-threatening medical issues, including bilateral dysplastic kidney disorder, that required her to be transferred to a children's hospital for a higher level of care. She remained hospitalized until her death. At the time of her birth, the mother and the newborn's cord blood tested positive for methamphetamine. DCFS opened an investigation and later indicated the mother for substance misuse by neglect. DCFS did not investigate the death for abuse or neglect.

Reason for Review: The newborn had two older brothers who were youth in care and had been subjects of eight child protection investigations in the year preceding her death. In February 2021, DCFS opened an investigation after receiving a report that the newborn's siblings were frequently absent from school, and the reporter said the mother appeared under the influence of drugs when they visited the home. The mother denied recent drug use but refused to take a toxicology screening without a court order. The newborn's then 9-year-old brother denied the mother used drugs other than marijuana, and local police

reported the mother had no history of drug use or possession charges. The mother declined intact family services. The investigation was ultimately unfounded. In March 2021, DCFS opened an investigation after receiving a report that the newborn's 9-year-old brother was frequently transported to school by various individuals because he did not want to be in his home, he had been observed carrying a large trash bag of his belongings, he frequently asked for food, and he had poor hygiene. DCFS received another report of bruises to the child, and that the brother was frequently unsupervised and had missed 57 days of school, which was taken for related information. The child reported he had bruises because he hit his head on a nail during a pillow fight. Four days later, DCFS opened an investigation after receiving a report that the 9-year-old and 11-year-old brothers had been seen riding their bikes after 2:00am and were rarely supervised. The CPI learned the11-year-old brother was at a slumber party the night of the reported incident, and both the family hosting the slumber party and a family friend who had been caring for him as part of a childcare plan denied the brother had been riding their bicycles that night. The mother again declined services. The CPI submitted a request to the State's Attorney asking that they file a neglect petition. DCFS unfounded both of the March 2021 investigations. In September 2021, DCFS opened four separate investigations. First, DCFS received a report that the 9-year-old brother had been attending school in dirty clothes, the 11-year-old had displayed escalating behaviors at school, the 11-year-old had not been receiving his ADHD medication, and the family home was uninhabitable. The CPI observed that the home met minimal standards with working utilities, including a working washer and clothesline. The mother reported the children often stayed with friends throughout the week. The mother did not appear under the influence and refused a toxicology screening. She reported the 11-year-old's ADHD medication was being changed to a slow-release version. The mother stated she needed help with an application for food stamps but declined intact family services. She disclosed she was three months pregnant. Eight days after the initiation of the first September 2021 investigation, DCFS opened an investigation after receiving a report that the mother was using needles and methamphetamine in the home in front of the 9-year-old, the mother's paramour had also been seen coming into the home with needles, and the brothers stayed with friends. The 9-year-old disclosed he had found needles in the home, had seen the paramour with a needle in his arm, and had seen his mother doing something with needles. The mother denied using drugs and declined intact services. Five days later DCFS opened a third investigation after receiving a report that the brothers were often outside at night unsupervised. The next day, the fourth investigation opened after the 9-year-old stated he did not feel safe at home, he had been absent from school because his mother did not wake him up, he brought money to school because he did not want his mother to steal it, and the home was dirty. In October 2021, the CPI sent a neglect petition to the State's Attorney, who reported he had not yet filed one. DCFS unfounded the first September investigation and indicated the other three. In November 2021, DCFS opened an investigation after receiving a report that the mother was using methamphetamine, and the 9-year-reported he had been sleeping outside because the mother sold his bed to purchase drugs. DCFS took protective custody of both boys and placed them with a relative and indicated the investigation for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. In January 2022, DCFS opened an investigation after the newborn tested positive for methamphetamine. The investigation remained pending at the time of the newborn's death. In March 2022, DCFS indicated the investigation for substance misuse by neglect and unfounded the investigation for medical neglect. The newborn's brothers remained in foster care.

Child No. 148	**DOB: 03/2011**	**DOD: 02/2022**	**Natural**
Age at death:	10 years		
Cause of death:	Candidal and enterobacter decompensated septic shock due to acute respiratory distress syndrome due to post transplant lymphoproliferative disorder		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Ten-year-old died at the hospital. She was medically complex and had received an organ transplant in 2021. In November 2021, the child had been diagnosed with COVID. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In September 2021, DCFS received a report that the child said she was afraid of her father, who had hit her face and had a drinking problem, and the parents argued in front of the children. The CPI met with the child's twin sister at school, who denied the allegations and reported she felt safe with her parents. The twin stated the mother was their primary caregiver, and both parents worked daily. The CPI met with the child and her mother at the hospital. The mother stated the child had been hospitalized due to an organ transplant she received six months earlier. The mother denied the father had an alcohol problem and reported the child experienced psychosis. She stated the child was homeschooled due to her medical conditions. The mother agreed to complete domestic violence and substance use assessments through a community resource. The child stated she was not afraid of her father and felt safe at home. She stated her parents avoided arguing around her and her twin sister. The child was observed to be free of visible injuries, excluding her medical treatment sites. The child, her twin, and her mother all reported the parents disciplined the children with removal of screen privileges. The CPI spoke with the reporter, who reiterated concerns about the father's drinking and stated the father was inappropriate with hospital staff and verbally aggressive toward the mother but was unable to provide examples. The next day, the CPI met with the father at home, and he denied the allegations. He agreed to complete a substance use assessment. In October 2021, DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by abuse and by neglect.

Child No. 149	**DOB: 06/2021**	**DOD: 02/2022**	**Natural**
Age at death:	8 months		
Cause of death:	Sudden unexplained infant death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Included in systemic issue report; report to Director June 30, 2022		
	See Death and Serious Injury Investigation 13		

Narrative: Eight-month-old was found cold and unresponsive by her babysitter, who called 911. The infant was transported to the hospital in cardiac arrest where she was pronounced deceased. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: In September 2021, DCFS received a report that the infant's father often left guns in reach of the children, was gang-affiliated, and the mother frequently left the children unsupervised. The reporter added there was domestic violence between the parents. The CPI did not see the family until almost four months later in January 2022. The family denied the presence of guns and violence in the home. The then 3-month-old infant and her 1-year-old sibling were assessed as safe. That month, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect and inadequate supervision.

Child No. 150	**DOB: 06/2020**	**DOD: 03/2022**	**Natural**
Age at death:	20 months		
Cause of death:	Cardiopulmonary arrest due to complications of cerebral palsy; significant contributing conditions of COVID-19 viral infection		
Reason for review:	Pending child protection investigation at time of child's death; closed intact family services case, and one indicated and two unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Twenty-month-old was found unresponsive at home. The toddler was not breathing when paramedics and law enforcement responded. CPR was initiated, and the toddler was transported to the

hospital, where he was pronounced deceased. The toddler had been born premature, at fewer than 24 weeks gestation, and spent the first eight months of his life in the NICU. He had been diagnosed with several lung and heart conditions and required a feeding tube. The mother reported the toddler had been breathing normally one hour earlier. Emergency responders reported the home was dirty, and the toddler had a bed but there was no indication he slept in it. DCFS investigated the toddler's death and indicated the investigation for death by neglect.

Reason for Review: In 2020, DCFS opened an intact family services case after the toddler was born substance exposed. In February 2021, the family's intact worker noted the mother had been inconsistent with program recommendations, and the intact case would be closed unsuccessfully. in March 2021, the intact case had not yet been closed when DCFS received a report that the then 8-month-old medically complex toddler was ready for discharge, and hospital staff were concerned the family could not provide the level of care the toddler would need because the father had not attended training sessions. Hospital staff stated the mother had rescinded all authorizations for them to communicate with the family's intact worker. The CPI administered a toxicology screening to the mother, who tested positive for cocaine and marijuana. One day prior to the toddler's discharge, hospital staff reported the mother had completed training successfully and had no concerns about her ability to care for the toddler. One week later, the CPI completed a nursing referral. DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by neglect. In April 2021, the intact worker again documented the mother was uncooperative with intact services. That day, DCFS received a report that the mother hit the toddler's then 16-year-old sister on her head, and the 15-year-old and 18-year-old siblings had scratches from the mother's paramour. The three siblings were transported to the hospital for treatment. The 16-year-old reported her mother was intoxicated and hit her 15-year-old brother. The mother stated she had to defend herself from her children, and the stepfather broke up the fight. The children were placed in a safety plan with a maternal cousin. One week later, the 16-year-old sister reported she wanted to go home, and the incident had been blown out of proportion. Hospital staff reported the toddler had presented for all follow-up appointments, and they had no concerns for his care. The mother was in a substance use treatment program at that time and was compliant with her treatment. DCFS unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse. In June 2021, the family's intact family services case was closed. In February 2022, DCFS received a report that the toddler had missed several appointments despite efforts to contact the mother to coordinate care and address potential barriers. The day before the infant's death, the CPI documented seeing the infant and his mother in a DCFS office and noted the infant was a healthy weight. The mother acknowledged she missed some appointments but stated she chose to do online appointments because the hospital was nearly two hours away. The CPI went to the home the following day and was informed the toddler was deceased. DCFS later indicated the investigation for medical neglect.

Child No. 151	**DOB: 09/2012**	**DOD: 03/2022**	**Natural**
Age at death:	9 years		
Cause of death:	Cardiac arrest		
Reason for review:	One unfounded and one indicated child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Nine-year-old medically complex child was brought to the hospital and pronounced deceased. She had been diagnosed with cerebral palsy, cardiac issues, hydrocephalus, seizure disorder, hypothyroidism, and anemia. She had undergone numerous surgeries, including open heart surgery, and required a g-tube, a shunt, a colostomy bag, and a wheelchair. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In May 2021, DCFS received a report that the child was not receiving appropriate medical care. The reporter stated the child had been brought to her neurologist after she removed her

g-tube the day before and had not received food or liquids, resulting in dehydration. The mother refused to admit her for fluids and tests. The neurologist allowed her to go home with the mother with instructions to return to the clinic the next day, but the mother did not do so. Staff reported that in the last 18 months the mother missed several appointments, including her yearly MRI, which was unusual. The mother told the CPI that an MRI had been scheduled, but medical staff were unable to find a vein to administer sedation for the MRI because the child had pulled out her feeding tube and became dehydrated. Medical staff offered to hospitalize the child overnight and conduct the MRI in the morning, but she declined because the child was upset, and she was concerned about the child contracting COVID in the hospital. The mother was receptive to intact family services and stated the child needed a new medical bed, new wheelchair, leg braces, water therapy, and sign language services. In July 2021, DCFS received another report alleging medical neglect because the child had missed six scheduled appointments. When the CPI went out the mother reported the child had been seen that day. The CPI noted she had submitted intact family services and nursing referrals. The child's primary care physician reported the child's frequency of missed appointments increased during the pandemic and noted the mother was concerned about the child contracting COVID, and the family had barriers with transportation. The doctor added that while attempting to coordinate care with the child's other providers, there was concern expressed about the mother's lack of follow through. The doctor stated the case met the criteria for medical neglect as defined but did not feel it was medical neglect at that time. The physician added the child's treatment team could work together to improve the family's compliance. The child's neurosurgeon initially stated the missed appointments constituted medical neglect, but later expressed a willingness to work with the family to improve compliance and stated it would only constitute medical neglect if the child missed her next appointment. In August 2021, DCFS indicated the mother for medical neglect in the first investigation. The mother later declined intact family services, as she was receiving other services and did not need services duplicated. In October 2021, DCFS unfounded the mother for medical neglect in the second investigation.

Child No. 152	**DOB: 10/2004**	**DOD: 03/2022**	**Natural**
Age at death:	17 years		
Cause of death:	Anoxic brain injury due to brain death		
Reason for review:	Child was a youth in care; two indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was taken to the hospital in cardiac arrest and put on life support. He was pronounced deceased four days later. The teen was living in a transitional care center, had multiple disabilities, and had been diagnosed with scoliosis and Duchenne muscular dystrophy, a terminal degenerative disorder. Five days before his death, the teen was taken to the children's hospital for respiratory issues, where he was intubated as a life-saving measure. DCFS did not investigate the teen's death.

Reason for Review: In June 2021, DCFS received a report that the teen was in the hospital for stomach pain and had not received any medical care for over a year. The mother, who brought him to the hospital, appeared intoxicated and later tested positive for cocaine and opiates. The teen was discharged to the mother's care. The CPI spoke to the mother, who reported she moved out of state. Three weeks later, while the investigation was pending, DCFS received a report that the mother was living in a homeless shelter and left the teen alone. Shelter staff reported the mother had been at the shelter for 17 days and had been written up for numerous violations of the program. The next day, DCFS took protective custody of the teen, and he was admitted to a children's hospital. During that investigation the teen tested positive for cocaine. DCFS indicated the mother in the first investigation for medical neglect and inadequate supervision. DCFS indicated the mother in the second investigation for substance misuse by neglect and inadequate supervision based on the teen's positive toxicology report and sufficient evidence the mother

left the teen alone in the shelter. The mother was recommended to complete a substance use assessment, treatment, and individual counseling, but she did not contact the caseworker until January 2022. DCFS had difficulty finding placement for the teen, and he remained hospitalized at the children's hospital. In February 2022, the teen was transferred to a transitional care center. His mother was approved for supervised video visitation.

Child No. 153	**DOB: 12/2021**	**DOD: 03/2022**	**Natural**
Age at death:	2 months		
Cause of death:	Complication of extreme prematurity		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was pronounced deceased at the hospital. She had been born premature, at 23 weeks gestation, and she remained hospitalized until her death. Her mother received prenatal care. At the time of her birth, the infant's mother tested positive for COVID, but the infant tested negative. DCFS did not investigate her death for abuse or neglect.

Reason for Review: In May 2021, DCFS received a report that the infant's siblings were regularly left home alone, and the people who lived there were drug dealers and involved in gang activity. The reporter added that law enforcement had recently been called to the home. The CPI saw the infant's 4-year-old and 6-year-old sisters, and her 6-year-old cousin. They denied being left home alone. The mother reported that the day of the alleged incident, she was at home and had a heated disagreement with a neighbor, but police did not come to her home. The CPI checked with local police who confirmed that they had not been called out to the home on the day of the alleged incident. The children's maternal grandmother reported no concerns with the mother's parenting and denied the mother was involved with drug dealers. One week after the Hotline report, DCFS unfounded the investigation for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 154	**DOB: 01/2022**	**DOD: 03/2022**	**Natural**
Age at death:	6 weeks		
Cause of death:	Bronchopneumonia of the lungs; significant contributing conditions of prone sleeping position and co-sleeping/bed sharing with an adult		
Reason for review:	Pending child welfare services referral at time of child's death; two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-week-old was found face down, not breathing, in a bed with her mother and a sibling. The mother reported she fed the infant, then laid on the bed with the infant next to her, and she found the infant was not breathing when she awoke. The father did not live in the home and was not present at the time of the death. DCFS investigated and unfounded the mother for death by neglect.

Reason for Review: The infant had two older maternal half-siblings who lived with their father and had visits with the mother. In January 2021, DCFS received a report that the infant's then 5-year-old and 10-year-old maternal half-siblings were exposed to drugs in their paternal grandmother's home, the 5-year-old had injuries on his arm, and the 10-year-old was being abused by her father. The siblings' father denied the allegations, the 5-year-old did not have injuries, and the 10-year-old denied she had been abused. DCFS unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse and substantial risk of physical injury/environment injurious to health and welfare by neglect. In July 2021, DCFS received a report that the siblings' father left the then 6-year-old in the 11-year-old alone at night, the 6-year-old had bruises on his ribs, and the reporter heard the father was selling methamphetamine out of the home. The CPI met with the family at their home. The siblings' father and his paramour denied the allegations. The 11-year-old half-sister denied the allegations, stated the mother

wanted her and her brother removed from their father's care, and stated her mother made the reports to DCFS. The half-sister reported they went to their grandmother's home when their father had to go somewhere without them. The 6-year-old half-brother had slight bruising, but they did not appear to be abusive, and the child said he did not know where the bruises came from. The siblings' father stated he saw the bruises after the children returned from a visit with their mother, during which they went to a water park, and he believed the child received the bruises there. The siblings' father declined services. DCFS unfounded the investigation for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. The day of the infant's birth, DCFS opened a child welfare services referral due to the mother's history with DCFS prior to 2021. The referral remained pending at the time of the infant's death.

Child No. 155	**DOB: 10/2021**	**DOD: 03/2022**	**Natural**
Age at death:	4 months		
Cause of death:	Severe chronic lung disease due to extreme prematurity		
Reason for review:	Open intact family services case at time of child's death; two indicated child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old died at the hospital. She was born premature, at 25 weeks gestation, and had remained hospitalized in the NICU with a lung infection. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: In May 2021, DCFS received a report that the infant's then 1-year-old maternal half-sister was brought to the hospital twice within one week while in the care of her mother's paramour, the infant's father. At the first hospitalization, she was unresponsive, had to be resuscitated, and remained in the hospital for a few days. Five days later, she was admitted with similar symptoms and possible seizures. An MRI revealed significant old and new brain trauma which were highly suspicious for abuse, and the family had not reported any previous injuries. An MRI the year before to diagnose optic dysplasia showed no brain bleeds at that time. DCFS implemented a safety plan barring the infant's father from the family residence and from having contact with the children. The infant's 3-year-old maternal half-sister denied the infant's father ever hurt her or her sister. The infant's father admitted he would sometimes hold the sister about a foot above the bed and drop her, and stated he was not gentle or careful when he flipped her over when she was choking, but he denied forceful actions against her. Medical staff reported the actions the father described were unlikely to cause the brain trauma, and there would need to be more force involved. In June 2021, DCFS ended the safety plan because the infant's father no longer resided in the home and confirmed the mother was at work when both incidents occurred. In July 2021, DCFS opened an intact family services case for the mother. Recommended services included parenting classes and domestic violence counseling. In September 2021, DCFS indicated the infant's father for head injuries by abuse. In November 2021, while the intact case remained open, DCFS received a report that the mother gave birth to the infant, and the infant was admitted to the NICU. The reporter stated the mother had been seen with a black eye, and the parents had been removed from hospital housing due to loud screaming and fights between them. The family's intact worker reported no knowledge of the father living in the family's home, the mother had been cooperative with services, and the father had been offered services shortly before the infant was born. The mother denied any arguments with the father and stated she received the black eye when she hit her head on the bed rail during labor. The father was denied access to the infant and was barred from the housing near the hospital, but the mother was allowed to stay. The infant's 3-year-old maternal half-sister reported the infant's father spent significant time in their home, and he sometimes stayed in the home while the mother ran errands. The mother denied she was in a relationship with the father and stated her only contact with him was advising him of appointments. She stated the 3-year-old did not understand time frames. The father reported he was homeless and sleeping in his car. In November 2021, DCFS allowed the father supervised visits with the infant in the hospital. In December

2021, DCFS indicated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect due to credible evidence he created an environment likely to harm the infant. DCFS unfounded him for substantial risk of physical injury/environment injurious to health and welfare by abuse because he had no unsupervised access to the infant since her birth. The family's intact case remained open when the infant died.

Child No. 156	**DOB: 07/2020**	**DOD: 03/2022**	**Natural**
Age at death:	20 months		
Cause of death:	RSV infection due to obstructive sleep apnea due to dilated cardiomyopathy		
Reason for review:	Child was a youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-month-old medically complex child was found unresponsive and not breathing by his maternal grandmother, with whom he was placed. The toddler was transported by ambulance to the hospital and later transferred to a children's hospital. Two days later, he was pronounced deceased. The toddler's diagnoses included biallelic mutation of the TTN gene, central cleft soft palate, neonatal hypotonia, global developmental delay, micrognathia, supraventricular tachycardia, and torticollis. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: In March 2021, DCFS received a report that after the toddler been admitted to the hospital for difficulty breathing, he gained more weight in two days than he had in the two months prior, so they suspected failure to thrive, and the mother was not bringing the toddler to his medical appointments. The CPI spoke with the toddler's treating physician, who stated the mother missed six appointments for the toddler, had refused medical consultation, and was not feeding the toddler properly. The mother denied the allegations. She stated the toddler gained weight because the hospital changed his formula. She said she missed appointments because of lack of transportation and declined the medical consultations because she wanted to be present. The mother added she wanted the toddler discharged. The next day, DCFS took protective custody of the toddler, his 2-year-old sister, and his 3-year-old brother. The children were placed with the paternal aunt. DCFS indicated the mother for failure to thrive, malnutrition, medical neglect of disabled infants, and substantial risk of physical injury/environment injurious to health and welfare by neglect. In July 2021, they were placed with their maternal grandmother. In September 2021, the children contracted COVID, and the toddler required hospitalization. He was discharged six weeks later. The mother visited him regularly but refused to engage in services and stated she would not cooperate until she had unsupervised visits with the children. In November 2021, the toddler was hospitalized due to respiratory concerns and had surgery; he remained hospitalized for over two months. The placement case remained open at the time the toddler died.

Child No. 157	**DOB: 02/2013**	**DOD: 03/2022**	**Natural**
Age at death:	9 years		
Cause of death:	Complications of chronic neurological conditions		
Reason for review:	Child was a youth in care within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-year-old was found unresponsive by his paternal grandmother, who had adopted him. The child was transported to the hospital by ambulance, where he was pronounced deceased. The child was medically complex. His conditions included cerebral palsy, congenital hydranencephaly, epilepsy, scoliosis, and quadriplegia. He also had a shunt and required feeding by g-tube. DCFS did not investigate the child's death.

Reason for Review: The child came into DCFS care in 2018 and was placed with his paternal grandmother. The child participated in occupational and physical therapy services, attended school

remotely due to the COVID pandemic, and his caseworker completed monthly visits. He attended medical appointments as scheduled, and the paternal grandmother worked with the child on his therapies at home. In June 2021, the paternal grandmother's adoption of the child was finalized.

Child No. 158	DOB: 03/2022	DOD: 03/2022	Natural
Age at death:	3 weeks		
Cause of death:	Viral pneumonia		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-week-old was found unresponsive by his parents, who contacted 911. The father began CPR, and the baby was transported by ambulance to the hospital, where he was pronounced deceased. The baby had last been seen alive the night before and slept in the same bed with his parents. The newborn had been born premature but had no other known medical complications. DCFS did not investigate the death for abuse or neglect.

Reason for Review: The newborn lived with his parents. He had two paternal half-brothers and a maternal half-brother. In March 2021, DCFS received a report that the father hit the newborn's then 6-year-old paternal half-brother with a belt and left a bruise. The father and the mother of the paternal-half brothers were separated and did not have an official custody arrangement. The CPI spoke with the mother of the paternal half-brothers, who stated she saw a bruise on the half-brother's bottom that looked like a belt, the other half-brother reported they witnessed the father use a belt, but the father said the boys had been roughhousing. The mother of the paternal half-brothers stated she had not been concerned in the past. The CPI met with the newborn's mother, who lived with the father. She reported she had never seen the father hit the children with a belt nor had she observed marks on their bodies. The father stated he had spanked the 6-year-old with a belt months earlier and had only used his hands to discipline the children since that time. He stated he believed the mark on the 6-year-old's bottom came from him scooting down the stairs. In May 2021, DCFS unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse.

Child No. 159	DOB: 07/2004	DOD: 04/2022	Natural
Age at death:	17 years		
Cause of death:	Cerebral palsy		
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 bed, cold to the touch, with labored breathing. The mother called 911. Responding paramedics performed CPR but were unable to resuscitate him. The teen was medically complex, with diagnoses of cerebral palsy, chronic respiratory disease, epilepsy, hydrocephalus, and developmental delays. He was confined to his bed and had a trach and g-tube. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In October 2021, DCFS received a report that the mother struck the teen's 10-year-old sister on her ear. The mother denied injuring any of her children and stated she sometimes disciplined her children with an open-hand hit to the arm, bottom, or back. The 6-year-old sister reported she felt safe at home and received discipline through time-outs. The 10-year-old reported her mother struck her but stated it was an accident, and her mother never hit her hard. The CPI noted no concerns when she observed the children. The CPI observed the teen, who had a daily in-home nurse. The children's pediatrician reported no concerns about their care and stated the mother called the clinic when she had concerns. In December 2021, DCFS unfounded the mother for substantial risk of physical injury/ environment injurious to health and welfare by abuse.

Child No. 160	DOB: 08/2009	DOD: 04/2022	Natural
Age at death:	12 years		
Cause of death:	Sepsis due to cellulitis		
Reason for review:	Pending child protection investigation at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-year-old was found unresponsive in her bedroom by her mother, who went to her room to administer her morning feeding and medication. The mother called 911 and performed CPR until first responders arrived. The child was transported to the hospital by ambulance, where she was pronounced deceased. She had cerebral palsy, required a g-tube, was quadriplegic, and received care from an in-home nurse five days per week. The child had been treated for cellulitis on her face four days before her death. Her mother reported she fed and gave the child her medication around 10:00pm the night before and checked on her again around midnight, and the child had a slight temperature but was otherwise normal. The DCFS investigation into the teen's death remains pending.

Reason for Review: In July 2021, DCFS received a report that the mother's paramour kicked in the door after the mother asked him to leave. The mother denied her paramour was physically violent with anyone in the home after kicking in the door, but the children were present. At that time, the mother was pregnant with the paramour's child. DCFS closed the investigation after the mother reported she was not in a relationship with the paramour, had not seen him since the incident, and was not in need of services. In December 2021, DCFS received a report that the paramour went to the mother's home and again kicked in the door when no one answered. He then reportedly punched the mother and knocked over a swing in which his then 3-month-old son was sitting. After the paramour left, the mother called police. Police stated the paramour would be arrested when he was located, and they provided information for the mother to obtain an order of protection. Police observed no injuries to the mother or the 3-month-old. The child's 6-year-old half-brother reported he was asleep when his father kicked in the door and denied observing the incident or seeing anyone fight in the home. The 9-year-old half-brother reported he witnessed the incident and saw the paramour yell at his mother. The mother reported that after the paramour came in, he tripped over the baby swing, retrieved a jacket, hit her, then left. The CPI observed no visible signs of abuse or neglect to the child or the 3-month-old. The child's in-home nurse denied concerns about the mother's ability to care for the child. In January 2022, police arrested the paramour for the incident, and the mother continued to report that she had not had contact with the paramour since the incident. She declined intact family services and reported she planned to pursue community resources. The children denied any recent incidents with the paramour. The child's pediatrician had no concerns about abuse or neglect. DCFS indicated the paramour for substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect. Six days before the death in April 2022, DCFS received a report that the paramour had been seen assaulting the mother and hurting a child while leaving the mother's home. The 6-year-old and 9-year-old siblings denied the paramour had been in the home. The mother acknowledged past incidents of domestic violence but denied the new report. The CPI confirmed there was no recent police involvement. The child died while the investigation remained pending. DCFS later unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect.

Child No. 161	DOB: 10/2010	DOD: 04/2022	Natural
Age at death:	11 years		
Cause of death:	Life threatening event at 5 months of age due to severe hypoxic ischemic encephalopathy due to chronic ventilator dependency		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Eleven-year-old was found unresponsive and was transported to the hospital by ambulance, where she was pronounced deceased. The child had lived in a pediatric long-term care facility since she was a toddler, as she required 24-hour care due to her persistent vegetative state and inability to survive without medical technology. Diagnoses included cerebral palsy, seizure disorder, hypertension, gastroesophageal reflux disease, and severe hypoxic encephalopathy. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: At the age of 5 months, the child was brought to the hospital in full cardiac arrest, and an EEG at the hospital displayed no brain activity. DCFS took protective custody of the child upon her discharge from the hospital. DCFS indicated her mother for medical neglect, inadequate supervision, and substantial risk of physical injury/environment injurious to health and welfare by neglect. She was eventually transferred to the long-term care facility she lived in at the time of her death. Her permanency goal was "cannot be provided for in a home environment." Her caseworker completed monthly visits and had regular contact with her case manager at the facility.

Child No. 162	DOB: 04/2022	DOD: 04/2022	Natural
Age at death:	8 days		
Cause of death:	Fulminant hepatic necrosis and failure due to interstitial pneumonia of the lungs and herpes simplex virus 2 infection		
Reason for review:	Pending child protection investigation and pending child welfare services referral at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-day-old was brought to the emergency room by her parents, who reported she had not been feeding that day then vomited. She became unresponsive in the emergency room and was pronounced deceased. It was reported the newborn was dirty, had a possible yeast infection, and injuries including a small laceration on the side of her head and a small, inflamed laceration to her anus. The mother reported a vacuum was used during childbirth, which hospital staff stated may have caused the injuries. At autopsy, there was no sign of blunt trauma or abuse. DCFS investigated the newborn's death and unfounded the parents for death by abuse.

Reason for Review: When the mother gave birth, DCFS received a report for a child welfare services referral after hospital staff learned the father had previous DCFS involvement, though no concerns were noted. The father had an unfounded report with another mother two years earlier during a custody dispute. The caseworker met the parents in the hospital, who reported they did not want services. The afternoon of the newborn's death, the caseworker visited the home and observed animal feces, trash, soiled carpets, and clutter. The caseworker called the Hotline to report the health and safety issues in the home, which was taken for investigation. The parents took the newborn to the hospital that evening. The assigned CPI did not see the newborn before she died. DCFS later indicated the parents for environmental neglect.

Child No. 163	DOB: 01/2013	DOD: 04/2022	Natural
Age at death:	9 years		
Cause of death:	Neuroblastoma		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-year-old died of neuroblastoma (cancer of the adrenal glands). DCFS did not investigate her death for abuse or neglect.

Reason for Review: In August 2021, DCFS received a report that police responded to the family home after the mother's paramour reportedly yelled at the child and pressed on her neck. The paramour fled the scene before police arrived. The mother told the CPI that the paramour grabbed the child and threw her on her bed when he became angry. The mother stated she was cooperating with police. She reported her paramour sometimes became upset but had never before become physical. The child corroborated the mother's statement. The child stated she was afraid of the paramour but felt safe with her mother. The CPI did not observe any marks or bruises on the child. The child's 5-year-old and 4-year-old siblings denied witnessing the incident and denied any abuse. The CPI documented the mother had changed the locks. The home was observed to be appropriate, and the children were assessed as safe. The CPI made multiple unsuccessful attempts to see the paramour. DCFS indicated the paramour for substantial risk of physical injury/environment injurious to health and welfare by abuse.

Child No. 164	DOB: 04/2016	DOD: 05/2022	Natural
Age at death:	6 years		
Cause of death:	Complications of congenital abnormalities and chronic health conditions		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Six-year-old medically complex child became unresponsive; the child was transported to the hospital by ambulance and pronounced deceased. The parents reported he had been congested for approximately two weeks and began vomiting the Friday before his death. The following Monday morning, they contacted his primary care physician to report his condition had not improved and were told to take him to the hospital and were preparing to do so when he collapsed. The child's diagnoses included GNAO1 gene mutation, a seizure disorder, gross motor delay, swallowing dysfunction, and he relied on a g-tube. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: The child had three foster siblings, ages 12 to 18, who were in the care of his mother. In August 2021, the court changed the permanency goals for the child's 12-year-old and then 14-year-old foster siblings to guardianship and changed the goal for the child's 18-year-old foster sibling to independence. That day, DCFS received a report that the foster siblings' biological mother had a bed in the home of the child's mother, and the reporter was concerned about the foster siblings' biological mother having access to her children. The child's mother and foster siblings all denied that the biological mother stayed overnight or was allowed unsupervised visits. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 165	DOB: 04/2013	DOD: 05/2022	Natural
Age at death:	9 years		
Cause of death:	Hypoxic respiratory failure due to progression of malignant brain tumor		
Reason for review:	Child was a youth in care; pending child protection investigation at time of child's death; one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-year-old died at the hospital two days after his maternal grandparents brought him there due to respiratory distress. The child had been diagnosed with malignant neoplasm of the brain when he was 2 years old and had undergone several treatments. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: The then 6-year-old child and his then 5-year-old brother came into DCFS care in 2020, during an investigation in which his mother was later indicated for burns by abuse; cuts, bruises, welts, abrasions, and oral injuries by abuse; and substantial risk of physical injury/environment injurious to health and welfare by neglect. They were placed with their maternal grandparents. In February 2021, DCFS received a report that the child's then 6-year-old brother disclosed his father had held a knife to him, and the father had a history of drug use. Following a formal investigation that included a victim sensitive interview, DCFS unfounded the investigation for mental injury, sexual penetration, and substantial risk of physical injury/environment injurious to health and welfare by abuse. In March 2022, DCFS received a report that the child's then 7-year-old brother had bruises on his arm, and the brother reported his father grabbed him during a visit. The CPI met with the brother and spoke with the maternal grandmother. She added the child's prognosis related to his brain cancer was poor. The children were assessed as safe because they were not in their father's care. The investigation remained pending at the time of the child's death. DCFS later unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse.

Child No. 166	DOB: 03/2022	DOD: 05/2022	Natural
Age at death:	2 months		
Cause of death:	Sudden unexpected infant death		
Reason for review:	One indicated and two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was found unresponsive by his mother, face-down, in his bassinette at 4:00am when she returned home from work. His mother began CPR and he vomited; she then called 911. The infant was transported to the hospital by ambulance, where he was pronounced deceased. The infant and his sister had been in the care of their father while the mother was at work, and the father left the home upon the mother's return. The father reported he fed the infant a bottle around 2:40am and placed the infant back in his crib. At the time of the death, the father had been ordered not to have contact with the mother due to two pending counts of domestic battery stemming from an incident in March 2022. However, the mother admitted she violated the no contact order because she did not have other childcare for the children while she worked. DCFS investigated and unfounded the father for death by abuse, and unfounded the mother for death by neglect.

Reason for Review: In November 2021, DCFS received a report that the parents had a history of domestic violence in the presence of the 1-year-old sister. The mother was residing at a shelter and had obtained an order of protection against the father. The next day, the CPI met with the mother, who confirmed she was living in a shelter and had been having troubles with the father. She denied physical incidents but stated the father yelled and intimidated her, and he had pushed her in the past. She stated she was pregnant but did not wish to reunite with the father. The sister was observed to be clean, free of injuries, and appeared comfortable with the mother. The father stated there was no current order of

protection, though there had been one in 2020. The father stated he watched the sister daily while the mother worked. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. In March 2022, DCFS received a report that the infant had been born substance-exposed, and the parents engaged in a verbal argument at the hospital regarding the infant's paternity. Hospital staff stated neither security nor police were called following the argument. Doctors reported the infant's umbilical cord tested positive for marijuana, but the infant did not have withdrawal symptoms and had been discharged. The mother admitted to using marijuana during pregnancy. She denied using any other drugs. The mother reported she did not reside with the father. The CPI observed a bassinette and crib for the infant and his sister, provided a pack-and-play, and discussed safe sleep with the mother. Less than one week later, while the investigation was pending, DCFS received a report that the parents engaged in a verbal altercation with the children present, and the mother called 911 for assistance. The CPI spoke with the father, who admitted to striking his car dashboard out of frustration during an argument but denied physically assaulting her and denied being in a verbal argument at the hospital. Eleven days before the infant's death, DCFS unfounded the second investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. Four days before the infant's death, DCFS indicated the father in the third investigation for substantial risk of physical injury/ environment injurious to health and welfare by neglect; DCFS unfounded the mother for the same allegation.

Child No. 167	**DOB: 01/2022**	**DOD: 05/2022**	**Natural**
Age at death:	4 months		
Cause of death:	Acute pneumonia		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old arrived at the emergency room by ambulance in cardiac arrest and later died. He and his twin brother had been brought to the hospital the day before for cough and congestion. The infant was discharged home with instructions to follow up in two days if his condition worsened. Medical staff advised the parents to give ibuprofen or acetaminophen. The infant's twin was in acute respiratory distress and was transferred to an out-of-state NICU because he was born with a cardiac issue. That evening, the parents left the infant and his 2-year-old sister with an aunt while the parents visited the twin out of state. The aunt noticed the infant's condition was getting worse, and she called the parents and then called 911. The DCFS investigation into the infant's death remains pending.

Reason for Review: One week after the infant's birth, DCFS received a report that police responded to the family home for a physical altercation between the parents that occurred in the presence of the infant's then 1-year-old sister. Police separated the parents but made no arrests. The CPI made a good faith attempt to see the family the following day. The CPI spoke with the mother by phone, who reported she recently gave birth to twins, who were in the NICU. The mother stated that the day of the incident, the father had been drinking and they began arguing, but she denied that the argument became physical. She stated the 1-year-old sister had been present while they argued. Later that day, the CPI went to the home and completed a home safety checklist and observed the home was appropriate and had safe sleeping arrangements. Five days later, the CPI spoke with the father, who denied the argument became physical, and provided the father with a referral for a community-based domestic violence resource. The next day, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect because both parents denied their argument became physical.

Child No. 168	DOB: 04/2022	DOD: 06/2022	Natural
Age at death:	6 weeks		
Cause of death:	Interstitial and bronchopneumonia of the lungs; significant contributing condition of prematurity		
Reason for review:	Open intact family services case at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-week-old was found unresponsive by her mother, who called 911. The infant had been born premature around 32 weeks gestation. The autopsy report noted the infant was well-nourished and exhibited no signs of trauma, co-sleeping, overlay, or drug intoxication. DCFS investigated the infant's death and unfounded the investigation for death by neglect.

Reason for Review: In October 2021, DCFS received a report that the infant's then 4-month-old brother was not bathed regularly, the mother missed WIC and doctor's appointments, and the mother had previously had a child removed from her care. The reporter added the parents were no longer together, and she was concerned about how the mother could care for the brother. The CPI met with the family at a hotel where they were staying. The mother reported they had been living with the infant's paternal great-grandmother until one month earlier, when the mother and father each moved back in with their mothers for additional support. The mother reported she took the brother to a wellness exam and vaccinations one month earlier, and she needed to re-enroll in WIC services because she had moved. She stated both she and the father worked full-time. She stated she had a 3-year-old child, who resided with his father. The infant's father reported he was on probation for battery. The father denied any drug use and stated he no longer drank alcohol. The parents stated they wanted to obtain an apartment but needed assistance, and they were willing to engage in intact family services. The infant's brother appeared clean, healthy, and the CPI noted the parents were attentive to his needs. The investigation was unfounded for environmental neglect. In November 2021, the intact family services case opened. Throughout their intact family services case, the intact worker made regular visits and followed up with service providers. Recommended services included parenting classes and mental health services for the father; parents were compliant. Both parents were employed full-time and maintained their apartment. The infant's brother continued to thrive. The intact worker documented multiple discussions regarding safe sleep practices. In March 2022, the intact worker learned the mother had only attended one prenatal visit while pregnant with the infant, and the brother had not been seen for his 9-month wellness exam. The mother expressed being overwhelmed at the many appointments she had to manage. The intact worker offered assistance, and the mother agreed to keep her appointments. The parents remained engaged in parenting classes and reported they attended counseling. In April 2022, the infant was born premature. In May 2022, the mother reported she and the father had separated, and she was concerned about the father having visits because she believed the father was using drugs not prescribed to him. The parents' attendance in parenting classes became inconsistent. Two weeks before her death, the infant was discharged from the hospital. Two days later, the intact worker met with the family at home, discussed safe sleep, and observed the infant's feeding log was incomplete. The intact worker discussed the feeding log with the parenting educator, who had reported she was to meet with the family at home twice per week to ensure the infant received adequate nutrition due to her strict feeding schedule and small size. The children's pediatrician reported they had been seen that day, and there were no concerns. The mother reported she and the father decided to work on their relationship. Three days before the infant's death, the intact worker received a questionnaire from WIC that stated the infant had been seen at a WIC office and the family was unable to purchase the infant's prescribed formula. The intact worker contacted the father, who reported they had an ample supply of formula.

Child No. 169	DOB: 09/2021	DOD: 06/2022	Natural
Age at death:	8 months		
Cause of death:	Viral pneumonia with focal bacterial pneumonia, significant contributing condition of mild viral myocarditis		
Reason for review:	Open intact family services case at time of child's death; two unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Eight-month-old was found unresponsive in his pack-and-play with a blanket wrapped around his neck. The mother called 911, and he was transported to the hospital by ambulance, then was transferred to a second hospital. CT scans showed extensive hypoxia from lack of oxygen, and medical staff reported he had old and new brain injuries and was having seizures. Two days later he was pronounced deceased. The mother had two roommates living with her at the time of the infant's death that she reported had been in the home for a few weeks. The mother reported that a few days before the incident, she had asked one roommate to watch the infant for approximately 45 minutes while she went to the store. The mother reported she found a knot on the infant's head when she returned, and she had not left the infant alone with the roommates since then. DCFS investigated the infant's death and unfounded his mother for death by neglect and internal injuries by abuse, but indicated her for substantial risk of physical injury/ environment injurious to health and welfare by neglect.

Reason for Review: The mother had an intact family services case dating back to 2019. The mother had developmental delays and a significant history of trauma. In June 2021, the court ended the short-term guardianship of the infant's then 2-year-old sister, who had been placed with her grandparents, but the mother was advised she needed to put daycare services in place before the sister could be returned to her care. In September 2021, DCFS received a report the mother and infant tested positive for cannabis upon the infant's birth, and the mother disclosed she had an open DCFS case. The mother reported she had a medical marijuana card and used marijuana to help with an eating disorder. She denied using other drugs. The family's intact worker and CPI made a joint visit to the home. They observed safe sleeping arrangements for the infant and assessed the home as safe. The intact worker told the CPI at an earlier visit drug paraphernalia was observed, and the father was advised that the parents could not use marijuana while caring for the children. DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by neglect. In October 2021, DCFS received a report that the mother was engaged in self-harming behavior. The intact worker informed the CPI she had no concerns the mother would self-harm and she had observed the mother to be able to care for the children properly. The intact worker reported that the mother had participated in psychological evaluations. The CPI and intact worker met with the mother and observed no recent injuries. The mother admitted to earlier self-harm but denied any self-harm since the infant's birth. The mother reported the sister still lived with the maternal grandparents. The parents completed toxicology screens that were positive for marijuana. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect due to a lack of evidence to support that she placed the children at risk of harm. The intact family services case remained open at the time of the infant's death.

Child No. 170	DOB: 06/2004	DOD: 06/2022	Natural
Age at death:	17 years		
Cause of death:	Complications of haemophilus influenza pneumonia and acute bacterial cystitis with prostatitis		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Seventeen-year-old medically complex child was at the home of his mother's former paramour when he had a seizure. The former paramour called 911, and the teen was transported to the hospital, where he was pronounced deceased. The teen's diagnoses included cerebral palsy, epilepsy, and

cytomegalovirus. At autopsy, the medical examiner noted his bladder was infected. Staff in the teen's primary care office reported no prior concerns. After the death concerns arose that the teen had been having seizures that were not reported and his anti-seizure medication had not been refilled for months. DCFS investigated the teen's death and indicated the former paramour for death by neglect and medical neglect and indicated the mother for medical neglect.

Reason for Review: In October 2021, DCFS received a report that the teen had been observed with bruises. School staff told the CPI the teen, who was nonverbal and had multiple physical and cognitive disabilities, had bruising on his arm that appeared to be in various stages of healing as well as a wound on his leg. They reported the teen's mother was appropriate, but she would not pick him up if the school called her. The mother stated the bruises were from the teen biting himself and that he had engaged in self-harm behaviors since infancy. She acknowledged there had been a few instances in which she did not pick him up from school and stated the school nurse called them often. The teen's four siblings, ages 4 to 12 years, all reported they felt safe at home, and they reported the teen bit himself; the former paramour corroborated this. The mother's former paramour reported that though he was no longer in a relationship with the mother, he regularly cared for the children. The children's primary care physician reported no concerns. In December 2021, DCFS unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse.

Child No. 171	**DOB: 04/2021**	**DOD: 06/2022**	**Natural**
Age at death:	13 months		
Cause of death:	Liver failure due to chronic health condition		
Reason for review:	Open intact family services at time of child's death; two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: One-year-old underwent a corrective surgery for biliary atresia, a condition that results in liver failure if not treated with surgery, in February 2022. The surgery was unsuccessful, and the toddler remained in the hospital and was placed on a transplant list. Four months later, the toddler died. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: In October 2021, DCFS received a report that the hospital could not contact the mother to inform her to bring the then 5-month-old toddler to the emergency room after lab results indicated he required immediate medical attention. The CPI was able to contact the family who agreed to take the toddler to the hospital immediately. The CPI met with the family at the hospital, assessed the child as safe and offered services to the family which they declined. DCFS unfounded the investigation for medical neglect. In January 2022, DCFS received a report that the toddler had not been seen by his pediatrician since October 2021 despite repeated attempts to contact the family, and the hospital had also been unsuccessful in contacting the family since November 2021. Four days after the Hotline report, the CPI contacted the family after several good faith attempts. The parents agreed to take the toddler to the hospital and provided an updated phone number and collateral contact. They stated the toddler had missed his November 2021 appointment, but no one answered the phone when they tried to reschedule. They added they were not able to read the toddler's discharge paperwork, or the letter sent by the hospital because the documents were in English, and their primary language is Spanish. The CPI assisted the parents with scheduling a new appointment and connected the family with an interpreter who would also attend the appointment. The agency that provided the interpreter reported they were also assisting the family with housing and utilities. The hospital reported the toddler was on the list for a liver transplant and was on a feeding tube. The hospital then provided an interpreter to train the mother how to use the toddler's feeding tube. In March 2022, DCFS opened an intact family services case. DCFS unfounded the investigation for medical neglect. In February 2022, the toddler had surgery for biliary atresia. He remained hospitalized, and the parents visited the toddler daily. The intact worker made regular visits to the family home and had no concerns about the wellbeing of the toddler's 4-year-old sibling.

TWENTY-YEAR DEATH RETROSPECTIVE

FISCAL YEAR	2003-16		2017		2018		2019		2020		2021		2022		2003-2022		
															TOTAL	AVERAGES	
CASE STATUS	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	#	%
Youth in Care	316	21.4%	20	18.5%	16	16.3%	22	17.9%	21	20.6%	11	9.0%	26	15.2%	**432**	**22**	**19.6%**
Unfounded DCP	348	23.5%	33	30.6%	37	37.8%	47	38.2%	29	28.4%	45	36.9%	53	31.0%	**592**	**30**	**26.9%**
Pending DCP	203	13.7%	22	20.4%	12	12.2%	19	15.4%	11	10.8%	20	16.4%	34	19.9%	**321**	**16**	**14.6%**
Indicated DCP	98	6.6%	8	7.4%	15	15.3%	9	7.3%	14	13.7%	14	11.5%	11	6.4%	**169**	**8**	**7.7%**
Child of Youth in Care	41	2.8%	1	0.9%	1	1.0%	2	1.6%	1	1.0%	0	0.0%	1	0.6%	**47**	**2**	**2.1%**
Open Intact	201	13.6%	15	13.9%	8	8.2%	8	6.5%	13	12.7%	14	11.5%	23	13.5%	**282**	**14**	**12.8%**
Closed Intact	64	4.3%	6	5.6%	3	3.1%	7	5.7%	5	4.9%	6	4.9%	8	4.7%	**99**	**5**	**4.5%**
Open Placement/ Split Custody	83	5.6%	2	1.9%	3	3.1%	4	3.3%	2	2.0%	9	7.4%	6	3.5%	**110**	**6**	**5.0%**
Closed Placement/ Return Home	27	1.8%	0	0.0%	0	0.0%	2	1.6%	1	1.0%	3	2.5%	3	1.8%	**36**	**2**	**1.6%**
Others	99	6.7%	1	0.9%	3	3.1%	3	2.4%	5	4.9%	0	0.0%	6	3.5%	**116**	**6**	**5.3%**
TOTAL	**1480**	**100%**	**108**	**100%**	**98**	**100%**	**123**	**100%**	**102**	**100%**	**122**	**100%**	**171**	**100%**	**2204**	**110**	**100%**

FISCAL YEAR	03-16	17	18	19	20	21	22	Totals 03-22
Total Deaths	**1480**	**108**	**98**	**123**	**102**	**122**	**171**	**2204**
Youth in Care	**316**	**20**	**16**	**22**	**21**	**11**	**26**	**432**
Natural	168	6	5	9	7	5	9	209
Accident	41	3	4	5	4	2	3	62
Homicide	74	6	4	6	4	2	9	105
Suicide	18	3	0	0	3	1	1	26
Undetermined	15	2	3	2	3	1	4	30
Unfounded Investigation	**348**	**33**	**37**	**47**	**29**	**45**	**53**	**592**
Natural	112	8	12	8	11	21	23	195
Accident	120	13	12	16	13	8	11	193
Homicide	56	6	4	11	1	6	11	95
Suicide	14	1	0	3	1	3	3	25
Undetermined	46	5	9	9	3	7	5	84
Pending Investigation	**203**	**22**	**12**	**19**	**11**	**20**	**34**	**321**
Natural	62	7	2	4	7	7	11	100
Accident	50	8	4	7	3	6	9	87
Homicide	39	2	4	2	1	3	6	57
Suicide	5	0	0	2	0	0	1	8
Undetermined	47	5	2	4	0	4	7	69
Indicated Investigation	**98**	**8**	**15**	**9**	**14**	**14**	**11**	**169**
Natural	32	3	4	3	6	4	4	56
Accident	34	3	2	3	3	4	2	51
Homicide	14	1	4	1	2	2	4	28
Suicide	3	0	0	1	1	2	0	7
Undetermined	15	1	5	1	2	2	1	27
Child of a Youth in Care	**41**	**1**	**1**	**2**	**1**	**0**	**1**	**47**
Natural	18	1	0	2	0	0	0	21
Accident	8	0	0	0	1	0	1	10
Homicide	6	0	0	0	0	0	0	6
Suicide	0	0	0	0	0	0	0	0
Undetermined	9	0	1	0	0	0	0	10
Open Intact	**201**	**15**	**8**	**8**	**13**	**14**	**23**	**282**
Natural	91	5	0	2	4	5	11	118
Accident	50	4	5	0	5	3	5	72
Homicide	26	2	1	2	2	3	4	40
Suicide	3	0	0	1	0	0	0	4
Undetermined	31	4	2	3	2	3	3	48

FISCAL YEAR	03-16	17	18	19	20	21	22	Totals 03-22
Closed Intact	**64**	**6**	**3**	**7**	**5**	**6**	**8**	**99**
Natural	19	2	1	5	4	2	2	35
Accident	19	1	1	2	0	2	3	28
Homicide	15	2	0	0	0	0	0	17
Suicide	0	0	0	0	0	0	1	1
Undetermined	11	1	1	0	1	2	2	18
Open Placement/ Split Custody	**83**	**2**	**3**	**4**	**2**	**9**	**6**	**110**
Natural	50	2	2	2	1	4	2	64
Accident	16	0	0	1	0	0	3	20
Homicide	9	0	1	1	0	1	1	13
Suicide	0	0	0	0	0	1	0	1
Undetermined	8	0	0	0	1	3	0	12
Adopted	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**2**
Former Youth in Care	**17**	**0**	**0**	**0**	**0**	**0**	**4**	**20**
Closed Placement/ Return Home	**27**	**0**	**0**	**2**	**1**	**3**	**3**	**36**
Interstate Compact	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**2**
Preventive Services	**34**	**1**	**1**	**0**	**0**	**0**	**0**	**36**
Subsidized Guardianship	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Child of Former Youth in Care	**4**	**0**	**0**	**1**	**2**	**0**	**0**	**7**
Extended Family Support	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**14**
Child Welfare Referral	**25**	**0**	**2**	**2**	**3**	**0**	**2**	**34**

** Autopsies that remain pending at time of publication are included in "Undetermined" manner. These tables have been updated to reflect the final manner of death for autopsy reports that were released after the OIG Annual Report in which the death was reviewed.*

PART III: GENERAL INVESTIGATIONS

GENERAL INVESTIGATION 1

COMPLAINT A Department contracted vendor with a $4.8 million, five-year contract to provide Supplemental Security Income (SSI) application services for youth in care failed to comply with a provision in their contract that required the vendor to use an Illinois certified Business Enterprise Program (BEP) subcontractor for 10% of the contract. In addition, the vendor fraudulently reported compliance with the provision.

INVESTIGATION The Department contracted with the for-profit consulting firm to review DCFS Youth in Care client files to determine eligibility for SSI and complete applications/ renewal applications for SSI benefits for those youth deemed eligible. The five-year, $4.8 million contract included an Illinois Department of Central Management Service's Business Enterprise Program (BEP) provision, whereby, the consulting firm was required to identify a predetermined certified Illinois BEP subcontractor to be used for 10% of the contract ($480,000). To become an Illinois certified BEP subcontractor a company must submit an application with documentation that the company is 51% owned and controlled by minorities, females, or persons with disabilities. The BEP provision of the contract was signed by both the consulting firm and the BEP certified subcontractor. The BEP provision stipulated that the vendor cannot amend the BEP plan after execution of the contract unless the vendor receives prior written approval from the Department. The contract further required the consulting firm to notify the Department of any change in subcontractor.

In FY 2014, the consulting firm reported to the Illinois BEP monitor a BEP expenditure of $102,398. However, financial records obtained by OIG investigators revealed that the consulting firm's total amount reported to BEP included their use of the BEP subcontractor for other contracts, unrelated to the Department's SSI contract. OIG investigators found that for work specifically performed for the Department's SSI contract, the consulting firm paid the BEP subcontractor $15,148; $87,250 less than originally reported to the BEP monitor.

In January 2016, as a profit driven decision, the consulting firm changed from the original BEP subcontractor to a different subcontractor, which was not BEP certified, for a 5% savings. The firm made the change without prior written approval from the Department, as required by the contract. The new subcontractor was not an Illinois certified BEP business, nor did they meet the criteria to become certified. Though company emails indicate the consulting firm's legal department reviewed the contract for BEP compliance prior to the change, the consulting firm's legal counsel admitted to OIG investigators that the consulting firm erroneously interpreted the BEP provision of the contract as an "encouraged goal."

In August 2016, the Department requested that the consulting firm report their use of subcontractors but received no response. After repeated requests, in April 2017 the consulting firm falsely informed the Department that they did not have any subcontracts. However, OIG investigators found that the firm had been subcontracting with the non-BEP certified subcontractor for the previous 15 months. The consulting firm's program manager and legal counsel stated to IG investigators that they again erred, explaining that the program manager did not consider the non-BEP certified subcontractor a "subcontract."

In July 2017, the Department requested an accounting of the consulting firm's BEP compliance. OIG investigators found that the inquiry prompted a series of internal consulting firm emails assessing whether they

were required to comply with BEP. In one of the emails, the program manager acknowledged the consulting firm had not been using a BEP subcontractor. In an internal response to this email, another employee confirmed that the contract contained the BEP obligation, quoting the BEP provision language within the email. Following the internal communications and before reporting compliance to the Department, the consulting firm attempted to cover their alleged prior misinterpretation of the contract by contracting with the initial BEP certified company and reassigning personnel to that company. However, that company was now under new ownership, with a new company name and was not BEP certified. OIG investigators found the consulting firm knew that this subcontractor lacked BEP certification and again failed to inform the Department of a change in subcontractors.

Following the change in subcontractors, the consulting firm fraudulently reported to the Department a $6,463 BEP expenditure in FY17 using the initially identified BEP subcontractor, despite not using that subcontractor since December 2015, 18 months earlier. The consulting firm's program manager claimed to OIG investigators that the consulting firm erred when they reported continued use of the initial BEP certified subcontractor on the compliance form.

The OIG investigation found that the new subcontractor misrepresented to the consulting firm that their Illinois certified BEP status was pending approval, when in fact the subcontractor had been denied certification, as it was not deemed to be 51% owned and controlled by minorities, females, or persons with disabilities. The consulting firm's legal counsel stated to IG investigators that that they changed to the new subcontractor in good faith, believing that the subcontractor's certification was pending. However, despite the subcontractor's misrepresentation, a pending application does not fulfill the BEP requirement. The consulting firm continued to contract with the company for a year and half without BEP certification and without approval from the Department.

The consulting firm hindered the OIG investigation by providing inaccurate and misleading documentation. The consulting firm initially falsely reported to OIG investigators a total BEP expenditure of $280,866. However, after elimination of billings of both non-BEP certified contractors, unapproved non-background checked personnel and duplicate billings, IG investigators found that in fact the BEP expenditure over the five-year contract period was just $64,232.

In addition to the BEP expenditure findings, it was reported to IG investigators that the youth in care SSI applications were not being completed by the consulting firm in a timely manner. It was alleged that the consulting firm's management regularly instructed staff who were not working on the Department's SSI contract to bill the Department's SSI billing code, potentially reducing the number of staff working on the Department contract. This action reportedly increased staff on the firm's less profitable contracts with other institutions.

The OIG investigation found that over the full five-year contract period, the consulting firm fulfilled just 13% ($64,232) of the contract's total BEP obligation ($480,000). The investigation found that on two occasions the consulting firm fraudulently reported their BEP expenditure and attempted to conceal their change in subcontract by falsely reporting use of the initial BEP subcontractor. The consulting firm has additional contracts with other Illinois state and local agencies. In November 2019, upon completion of the OIG investigation, the OIG referred this matter to the Illinois Attorney General's Special Litigation Bureau. The Attorney General's Office's investigation is pending.

RECOMMENDATIONS

1. This report should be shared with any entity in Illinois contracting with the consulting firm including but not limited to the Illinois Department of Aging, the Illinois Department of Healthcare and Family Services, the Illinois Department

of Human Services, and the Chicago Public School System for consideration in connection with a review of their respective contracts for compliance.

The Department agrees. The report has been shared.

2. This report should be shared with the Illinois Department of Central Management Service's (CMS) Business Enterprise Program (BEP) for consideration in connection with any application submitted by the subcontractor and any future BEP Utilization Plans submitted by the consulting firm.

The Department agrees. The report has been shared.

3. This report should be shared with the Office of the Governor.

The Department agrees. The report has been shared.

4. The report should be shared with all Illinois Agency Procurement Officers.

The Department agrees. The report has been shared.

5. This report should be shared with the Illinois Auditor General.

The Department agrees. The report has been shared.

6. The Department should not enter into any future contracts with the consulting firm.

The Department agrees. The Department agrees that there should be no further contracts with the vendor. DCFS does not have the authority to comply with this recommendation. To be consistent with 30 ILCS 500/50-65, the Department must follow the determination of the Chief Procurement Officer for the State of Illinois regarding future contracts with the vendor. The Department will share this report with the Chief Procurement Officer and recommend that they cease any future contracts with the vendor.

GENERAL INVESTIGATION 2

COMPLAINT A 14-year-old youth in care was alleged to have lived in an unauthorized placement for almost a year with an aunt, who had a substantial history of drug use including a conviction for involuntary manslaughter after injecting a man with a lethal dose of heroin, and who had lost custody of her own children. While living with the aunt, the aunt brought the youth in care to the emergency room for complications of an untreated sexually transmitted disease. Hospital staff reported that the aunt appeared intoxicated and left with the youth in care prior to receiving treatment.

INVESTIGATION In 2009, the then 3-year-old youth in care first came to the attention of the Department, as she was taken into protective custody, and her parents were indicated for neglect. The court returned the child to her mother two years later in 2011. In 2015, an intact family services case was opened after the mother was indicated for substantial risk of physical injury/environment injurious to health and welfare to the minor. A few months later, the mother, who was heavily involved in drugs, gave guardianship of the then 10-year-old minor to the aunt. Over the next two years the minor lived with the aunt as well as two other family members. In January 2018, after the aunt pleaded guilty to multiple drug charges and involuntary manslaughter for injecting a man with a lethal dose of heroin, the aunt was sentenced to six

years' incarceration and imprisoned. The mother gave guardianship of the then 12-year-old minor to her 31-year-old second cousin. In April 2018, the Department was granted custody of the youth after the second cousin was indicated for sexual penetration and substantial risk of physical injury/environment injurious to health and welfare to the minor. The now youth in care's placement case was assigned a private agency. Within the next three months, the youth in care lived in two foster homes and was psychiatrically hospitalized for suicidal ideations.

From July 2018 to September 2019, the youth in care lived in three different specialized foster homes, and within days of being placed in the third home, the 14-year-old youth in care ran away to stay with the aunt who had been paroled a few months earlier. The private agency worker did not contact the Department's placement clearance desk at the time of the unauthorized placement. The private agency worker and supervisor told OIG investigators that they knew the aunt had a felony, per the aunt's self-report, but did not know the specifics of the conviction and that because they knew the aunt would not pass placement clearance it was unnecessary to run the clearance. OIG investigators found that had the worker contacted placement clearance the worker would have been informed that the aunt had recently been paroled after a prison sentence for involuntary manslaughter, had a history of convictions for drug possession, fraud, burglary/theft, and probation violations. Additionally, the worker would have been informed that the aunt had been indicated by the Department for substance misuse by neglect after giving birth to an infant who tested positive for opiates and amphetamines and lost her parental rights to her children in 2012. All of which, the worker told OIG investigators, she was unaware.

OIG investigators found that while living with the aunt, the youth in care did not attend school or counseling and did not take her psychotropic medications. The youth in care also had a 19-year-old boyfriend from whom it is believed she contracted an STD that resulted in her being hospitalized. The youth in care frequently did not come home and the aunt provided little supervision and direction. Additionally, there was frequent police involvement at the aunt's home.

During the unauthorized placement with the aunt, the private agency worker made minimal in person visits to the aunt's home and in 2020 made just one visit in seven months, though the worker documented meeting with the youth in care in the community and frequently texting with the youth in care. OIG investigators found that the worker made little contact with the youth in care's school and did not follow up with medical providers to determine if she was keeping psychiatric or medical appointments or taking her medication. The worker also did not contact the aunt's parole officer to check whether the aunt was compliant with toxicology screening and other services. The worker made little or no attempt to place the youth in care in an approved foster home. A Department permanency achievement specialist offered to assist the worker in finding an appropriate foster home, but the offer was declined by the private agency supervisor. Though both the youth in care and the aunt expressed repeated concerns for the youth in care continuing to reside in the aunt's home due to behavioral problems by the youth in care, the worker on multiple occasions attempted to negotiate the youth in care staying in the placement. Though there was repeated discussion that the youth in care may be a candidate for residential placement the worker never facilitated a clinical referral to determine if residential would be appropriate until after the 15-year-old youth in care was removed from the aunt's home due to a new child protection investigation called into the Hotline.

In September 2020, the Department initiated a child protection investigation after receiving a report that the then 15-year-old youth in care came to the emergency room with complications of a sexually transmitted disease that was suspected to be caused by the youth in care's 19-year-old boyfriend. The reporter stated the aunt accompanied the minor to the hospital but was suspected to be under the influence of drugs and was nodding off. The reporter told the Hotline that the youth in care and aunt were informed that the minor had an infection that needed to be treated by a specialist at a pediatric hospital, but the aunt took the youth in care and left the emergency room against medical advice. Due to the child protection investigator's intervention, the youth in care was transported to the hospital the next day and treated. The youth in care was then placed with another

relative. The aunt tested positive for amphetamines and methamphetamines and was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect.

An emergency hearing regarding the youth in care's unauthorized placement was conducted. The Assistant State's Attorney and GAL expressed concern about the length of time the youth in care had been left in the home and failure to report the aunt's history per requirements in periodic court reporting by the caseworker. The juvenile court judge ordered the youth in care's case to be removed from the agency and reassigned to the Department.

RECOMMENDATIONS

1. This report should be shared with the involved private agency. The agency should pursue disciplinary action in accordance with the agency personnel policy.

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

2. The Department should develop procedures for monitoring of unauthorized placements. The procedures should include frequency of required home visits, contact with school and other service providers and GAL notification requirements. For youth in care under the age of 17, procedures should require a minimum of three visits per month.

The Department agrees. A multi-disciplinary workgroup met to review existing policy, current practice issues and barriers and make initial recommendations related to unauthorized placements. The workgroup submitted recommendations to the Department's leadership team. In addition, the Department and private agency partners conducted a review of youth currently in unauthorized placements to ensure a plan is in place for those youth. The Department's next steps will include continued identification of needed policy changes and processes for youth in care who are in unauthorized placements.

3. Any unauthorized placements for youth in care under the age of 17 and that last more one month should be referred for a Clinical Intervention Placement Preservation staffing.

The Department agrees. A multi-disciplinary workgroup met to review existing policy, current practice issues and barriers and make initial recommendations related to unauthorized placements. The workgroup submitted recommendations to the Department's leadership team. In addition, the Department and private agency partners conducted a review of youth currently in unauthorized placements to ensure a plan is in place for those youth. The Department's next steps will include continued identification of needed policy changes and processes for youth in care who are in unauthorized placements.

GENERAL INVESTIGATION 3

COMPLAINT

While conducting a separate investigation, OIG investigators identified deficiencies in a child protection investigation regarding allegations that a then 23-year-old adult son living in a specialized foster home sent a photograph of his genitals to a then 14-year-old youth in care and that there was sexual contact between the adult son and the 14-year-old youth in care.

INVESTIGATION

The Department placed the then 12-year-old youth in the specialized foster home in July 2018, after removing her from the home of her relative guardian, who the Department indicated for sexual penetration and substantial risk of physical injury/environment injurious to the health and welfare of the youth. The Department referred the youth's placement case to a private agency, and the youth's clinical staffing report stated she was experiencing depression and PTSD symptoms attributed to the sexual abuse but had no behavioral issues. However, over the following year, the foster parents reported the youth became increasingly difficult, stating she stayed out past curfew and posted inappropriate pictures of herself on social media. In June 2019, the foster mother gave notice of removal for the then 13-year-old youth due to concerns regarding her behavior, and the youth moved to a different placement on that same day.

In September 2019, the Department initiated a child protection investigation after the then 14-year-old youth disclosed to her caseworker that the 23-year-old adult son from her previous foster home sent her a picture of his genitals. It was additionally reported that the youth stated there was also "some physical contact" regarding the adult son, but the 14-year-old claimed it was consensual. The youth declined a victim sensitive interview at the Child Advocacy Center (CAC), stating she previously participated in one regarding her relative guardian and did not want to go through that again. The youth also reported she told her caseworker in May 2019 that the adult son was touching her, but the caseworker did not believe her. In her OIG interview, the caseworker stated the youth had not previously reported sexual contact with the adult son; however, OIG investigators found prior statements from that same caseworker in which she minimized the allegations that the youth disclosed about sexual contact with the adult son while she was still living in the specialized foster home.

During the child protection investigation, the child protection investigator received an email from a different caseworker relaying information that another youth, who was 12-year-old at the time, had at least two respite stays at the same specialized foster home where the adult son lived. The email noted there was suspicion of grooming behaviors towards the 12-year-old, though the 12-year-old did not disclose any behaviors that rose to the level of abuse. In this email, the caseworker inquired if this information could help with the current investigation and if the 12-year-old should partake in a CAC interview. OIG investigators found that the child protection investigator never followed up on the information or responded to the caseworker.

The child protection investigator spoke with law enforcement after they interviewed the 23-year-old adult son, who confirmed it was his genitals in the picture but claimed the youth stole the picture from his unlocked computer. The adult son further alleged that after the youth left the specialized foster home, she attempted to use the picture to blackmail him for money. The police officer told the child protection investigator that he believed the adult son was telling the truth, because the officer knew him, and he never had any prior complaints about him. The child protection investigation file contained a copy of the police report, which did not indicate that law enforcement forensically analyzed the adult son's computer, phone, or picture to verify his statement.

The police report also contained screenshots of the text messages between the youth and the adult son, and the child protection investigator summarized in SACWIS the messages in which the youth asked the adult son for money in exchange for deleting the picture. The child protection investigator did not document the other text messages from the police report that appeared to corroborate the youth's statement, including one in which the adult son appeared to admit to sending the youth the picture. There was no indication that the child protection investigator nor law enforcement questioned the adult son about the discrepancies between his statement and the information in the text message exchange. It also appeared no one interviewed the youth to reconcile the

conflicting statements or attempted to create a timeline to determine if the photograph came into the youth's possession while she was living at the specialized foster home or in the three months since she left the home.

Almost two months after the call to the Hotline, the child protection investigator contacted the reporter, who confirmed the information in the Hotline report. The reporter added the youth's caseworker first called the Hotline after speaking with the youth and seeing the picture and related messages from the 23-year-old son; however, the Hotline worker coded the call as information only and did not initiate an investigation. The reporter disagreed with that decision and called the Hotline the next day, which then initiated the child protection investigation. Hotline administrators stated to OIG investigators that the caseworker's call should have been taken as an investigation and addressed the matter with the Hotline worker. The child protection investigator did not speak with the youth's caseworker, telling OIG investigators that she attempted to contact the caseworker but was unable to reach her. The child protection investigator did not document these attempts. However, the caseworker confirmed to OIG investigators that the youth showed her the picture and messages from the adult son that prompted her to call the Hotline, reporting after the adult son sent the picture, he then messaged the youth, stating he sent the picture by accident and intended to send it to someone else. This report contradicted the adult son's statement that the youth stole the picture off his computer.

The Department unfounded the adult son for sexual exploitation of the 14-year-old youth and closed the investigation. In her OIG interview, the child protection investigator stated she found no corroborating evidence that the adult son sent the inappropriate picture to the youth. The child protection investigator explained the adult son denied the allegations, the foster mother reported observing no issues between her adult son and the youth when she lived in the foster home, and anyone in the home could access the son's unprotected computer.

RECOMMENDATIONS

1. The Department should pursue disciplinary action against the primary child protection investigator in the September 2019 investigation.

The Department agrees. The child protection investigator received an 8-day suspension.

2. This report should be shared with the involved caseworker's private agency. The agency should pursue disciplinary action of caseworker in accordance with the agency's personnel policies.

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

GENERAL INVESTIGATION 4

COMPLAINT

A Department caseworker violated professional boundaries by developing a personal relationship with a youth in care assigned to her caseload. It was alleged that the caseworker regularly took the youth in care to the caseworker's church, referred to the youth in care's baby as her granddaughter, and placed the youth in care's baby with a church friend after the baby came into the care of the Department.

INVESTIGATION

The subject youth in care was in foster care from 2004 to 2012 when she was adopted at the age of 10. In January 2019, the adoptive parents reported to police that the then 16-year-old youth ran away and was missing. The police found the youth three weeks later, and the Department initiated an investigation after the adoptive parents refused to take the youth home. The adoptive parents were later willing to bring the youth home, but the youth refused, stating she wanted a fresh start.

In February 2019, the Department was granted temporary custody of the 16-year-old youth in care under a no-fault dependency. The case remained with DCFS, and the youth in care was placed in a traditional foster home. The youth in care first encountered the caseworker named in the OIG complaint while the caseworker was visiting another youth in care in the foster home; at this time, the subject caseworker was not assigned to the subject youth in care's case. During the visit, the 16-year-old youth in care told the caseworker that she knew the caseworker's children and asked about the caseworker's daughter. Six weeks later, the youth in care ran away from the foster home.

In May 2019, the youth in care's case was transferred to the caseworker named in the OIG complaint. In violation of the DCFS Code of Ethics for Child Welfare Professionals, the caseworker did not tell her supervisor that the youth in care knew her children. In July 2019, the youth in care was found at a relative's home. She tested positive for marijuana, and a medical exam confirmed she was pregnant. The youth in care was returned to the former foster home with a plan to move her to a maternity home for pregnant women and their children. The maternity home was not licensed by the Department and rarely served youth in care. The caseworker's supervisor informed OIG investigators that the area lacked resources for pregnant and parenting youth in care, and other placement resources were not available. The supervisor and caseworker could not remember if they discussed with the foster family about the youth in care remaining in the home. The foster mother told OIG investigators that she was willing to maintain the youth in care's placement, but the permanency team presented the youth in care's return to the foster home as temporary.

In August 2019, the then 17-year-old youth was placed at the maternity home, transferred to the local high school, and tested negative for all drugs. Procedures dictate that the Department issue a monthly board payment to the foster parent or facility with which a youth in care is placed. The Department, however, did not have a contract with the unlicensed maternity home and, as such, did not issue a board payment nor provide the youth in care with any financial support during her nine-month stay at the maternity home.

Over the next months, the youth in care received routine prenatal care, engaged in parenting services, and missed some school. The youth in care started individual counseling but was hesitant to engage in the sessions. The caseworker updated the youth in care's service plan to reflect her participation in these services and identified substance use as a risk factor due to the youth in care's previous marijuana use. The caseworker, however, did not include tasks in the service plan to address the youth in care's marijuana use and did not refer the youth in care for a substance abuse assessment.

In December 2019, the caseworker and her daughter were present at the hospital when the youth in care's baby was born. The caseworker failed to document her presence at the hospital in SACWIS or in the Child/Youth Incident report. The caseworker asserted to OIG investigators that her daughter and the youth in care became friends independent of the youth in care's case; both girls attended the same high school. The youth in care informed OIG investigators that the caseworker was the only adult she knew in the area when she moved to the maternity home. Multiple maternity home staff members reported that caseworker took the youth in care and her baby to church with the caseworker's entire family. The caseworker confirmed that she and her family would regularly take the youth in care and her baby to church, spend all day with them, and then go out for dinner for a period of four to five months. Contrary to the caseworker's statements to OIG investigators, the caseworker's supervisor was unaware that the caseworker was taking the youth in care and baby to church.

In January 2020, the permanency supervisor documented the youth in care was cooperative with school, counseling, and medical appointments and the caseworker did not have concerns about the baby being in the young mother's care. The maternity home administered two toxicology screenings to the youth in care that month, and both were negative for all drugs, including marijuana. The therapist documented the youth in care made progress in therapy; the therapist did not indicate a need for nor recommend the youth in care cooperate with a psychiatric assessment. At the end of January 2020, the caseworker faxed documents to the maternity home on DCFS letterhead permitting the caseworker's daughter to transport the youth in care and her baby to

school and daycare respectively. Among the faxed documents was a consent form signed by then 17-year-old youth in care, allowing maternity home staff to discuss the youth in care's case around or with the caseworker's daughter. The consent was not signed by the DCFS Guardianship Administrator. The caseworker told OIG investigators that the youth in care refused to get up for school, and it was the maternity home's idea to have the caseworker's daughter drive the youth in care; maternity home staff, however, did not remember how the arrangement came about. The caseworker told OIG investigators that her supervisor directed her to get a consent form to protect herself, but the supervisor said that she had never seen the documents.

In April 2020, the Department initiated an investigation after the then 18-year-old youth in care left the maternity home with her then 3-month-old baby. The reporter stated the youth in care went to the residence of a female friend, where there was prior drug use. The Hotline worker noted the youth in care had previously lived with this female friend until the youth in care was removed from the home due to using drugs with the woman. There was, however, no record that the youth in care was ever placed with the woman or removed from her care, but the misinformation would later be incorporated into the youth in care's DCFS records. The caseworker told the child protection investigator that the youth in care had mental health and substance use issues that the youth in care refused to address. The caseworker also stated the youth in care was told that protective custody of the baby would be taken if the youth in care left her placement, as the youth in care did not have the mental capacity to care for the baby on her own. The Department staff asked if the youth in care had anyone for support, and the caseworker identified herself as a positive support for the youth in care, adding her supervisor had asked the caseworker about being fictive kin for the baby. The supervisor confirmed to OIG investigators that she asked the caseworker if she considered being fictive kin for the baby, because at the time, the supervisor thought the youth in care would be in favor of this. The supervisor also stated the case would have been reassigned if the caseworker served as a placement for the baby.

The next day, the youth in care returned a call to a child protection investigator and provided her location. The youth in care stated she did not want the caseworker to accompany the child protection investigator, nor did she want the Department to take her baby. The youth in care was found at a relative's home who had previously been approved as a visiting resource. The child protection investigator found the baby was safe and cared for, but she took protective custody of the baby because the youth in care left the placement. The child protection investigator advised there were concerns about the youth in care's mental health and substance use issues, and the youth in care replied she was in therapy and did not have substance use issues. The child protection investigator spoke to the youth in care's therapist, who reported the youth in care called into her session the previous week. A maternity home staff member told the child protection investigator that the youth in care had recently stopped participating in services, missed two counseling sessions, and was not meeting the baby's emotional needs. The youth in care's parenting coach told OIG investigators that she regularly spoke with this staff member, who did not report these same concerns. At the time of the OIG's investigation, the staff member no longer worked for the maternity home and was employed in a leadership position at CASA.

The baby was brought into care and placed in a licensed foster home. The temporary custody order stated the youth in care displayed erratic behavior, did not have skills to care for or protect the baby, and did not complete services. The youth in care's family case with the baby was assigned to the caseworker, who continued to be the primary worker on the youth in care's dependency case for the next four months. The supervisor told OIG investigators that at the time of the assignment, she was unaware that Department Procedures prohibited the same worker from being assigned to both cases. Over the next few months, the youth in care provided updates to the caseworker about where she was living, obtaining employment, and continuing services with the parenting coach. The caseworker established the initial service plan for the youth in care's family case, which tasked the youth in care to meet with a psychiatrist on a regular basis, complete psychological and substance abuse assessments, and comply with the assessment's recommendations for treatment. The service plan also required the youth in care to take her prescribed medication, but there was no documentation that the youth in care was ever prescribed medication. The caseworker did not refer the youth in care for a psychiatric or a

substance abuse assessment but told her supervisor and other stakeholders that the youth in care refused to participate in these services. The caseworker documented the youth in care made unsatisfactory progress on the service plan for the youth in care's dependency case. Additionally, the caseworker did not ask the youth in care to submit to a toxicology screening in July 2020 when the youth in care needed placement and cooperated with a Healthworks exam. The caseworker placed the youth in care with an unlicensed fictive kin family that the caseworker set up through her church. The youth in care told OIG investigators that she met the family at the caseworker's church, and she did not have a prior relationship with the family. The caseworker informed OIG investigators that she and the mother of the family had been close friends for years, and the caseworker was trying to find a home that youth in care would not run from.

In early August 2020, the youth in care completed substance abuse and mental health assessments, which determined she did not meet the criteria for substance use disorder treatment nor psychiatric services; the referrals were completed by a private agency program working with the youth in care. Three weeks later, the youth in care's dependency case was transferred to a private agency (POS) caseworker. The POS caseworker told OIG investigators that she had concerns about the youth in care's dependency case, stating the service plan was flawed, and the DCFS caseworker should not have rated the youth in care unsatisfactory on services she had previously completed. The POS caseworker also informed OIG investigators that during the transition meeting, the DCFS caseworker and her supervisor talked about the youth in care's close relationship with the caseworker's daughter.

In September 2020, an assistant state's attorney (ASA) contacted the DCFS caseworker regarding the upcoming dispositional hearing for the youth in care's family case, as the ASA did not see any evidence of the youth in care's inability to care for the baby. The DCFS caseworker responded that the youth in care was not mentally ready to parent the baby, as the youth in care was not cooperating with the Department and was manipulative with her POS caseworker and foster family. The DCFS caseworker sent her draft of the dispositional court report to the ASA, in which the DCFS caseworker wrote the youth in care was not completing her service plan, abusing marijuana and alcohol, not completing her classes, and not following the rules of the foster home.

The youth in care's living arrangement in her foster home became strained, as the then 18-year-old youth in care stayed out past curfew and consumed alcohol and marijuana. The youth in care confided to her POS caseworker that she was becoming increasingly uncomfortable and confused regarding the dual relationships between her, her foster family, and the DCFS caseworker. In October 2020, the POS caseworker arranged for the youth in care to move into transitional living program. The following week, the youth in care began individual therapy with a new counselor, who noted the youth in care exhibited a high level of willingness to participate in services and seemed motivated. The therapist later diagnosed the youth in care with adjustment disorder but did not recommend a psychiatric evaluation.

At the end of October 2020, during the dispositional hearing for the family case (assigned to DCFS), the POS caseworker reported that the parenting coach expressed no concerns regarding the youth in care, who was doing well and appeared bonded with her baby. The POS caseworker stated the youth in care was earning good grades at night school, and although there had been reports of the youth in care being under the influence of substances, the substance abuse assessment did not reveal the need for treatment. The judge set the goal for the baby to return to the mother's care by December 2020, further stating the Department should triple the youth in care's visits with her baby and begin overnight visits the following week to prepare for the baby's return. After the hearing, the DCFS caseworker gave her supervisor a copy of the court order, and the two discussed the need to increase visitations. The caseworker told her supervisor that the judge only alluded to overnight visitation. The supervisor informed the ASA that they would increase the visits, but the visits would remain supervised due to the youth in care's lack of engagement in services and noncompliance with psychiatric care and mental health. The supervisor told OIG investigators that at the time, she believed the DCFS caseworker's reports about the youth in care's noncompliance and assumed the Department had record of this.

The ASA informed the supervisor that her interpretation was incorrect, and if the Department did not follow the judge's instructions, she would have him sign a more detailed order. A week after the hearing, the youth in care and her POS caseworker met with the assigned DCFS supervisor to express frustration over the lack of increased visits. The supervisor advised that supervised visits would increase until the youth in care submitted to a toxicology screening, took another substance abuse assessment, and someone confirmed that the youth in care had never been prescribed medication. The youth in care stated to her knowledge, she had never been prescribed medication besides prenatal vitamins. The supervisor told OIG investigators that the caseworker told her that the youth in care had been on medication for ADHD and an untreated psychiatric condition. The next day, an emergency hearing took place, and the ASA reported that the DCFS caseworker and supervisor were not complying with the judge's orders regarding the increased visitations. The judge stated his orders needed to be followed and clarified that the youth in care did not need to complete another substance abuse assessment, as it was not court ordered for the youth in care to do so.

Five days after the emergency hearing, the youth in care's family case was reassigned to another DCFS caseworker. The DCFS supervisor remained unchanged, and the supervisor documented that there was no record of psychotropic medication for the youth in care, and so psychiatric care and medication had been ruled out. The supervisor also noted a test was needed to verify any marijuana and alcohol use and that results from a recent toxicology screening administered by the previous DCFS caseworker were unknown. The new DCFS caseworker referred the youth in care for a drug and alcohol toxicology screening the next day, and the youth in care tested positive for marijuana. This was the first time the youth in care was referred for a drug and alcohol screening since her family case opened six months earlier.

In late January 2021, the baby's foster parents gave notice for the baby's removal, and the baby was placed with the youth in care's former fictive kin placement, who were also the DCFS caseworker's church friends. The youth in care informed OIG investigators that she identified the family as a placement for her baby, stating if she did not have baby placed there, the permanency supervisor mentioned sending the baby away to a long-term placement. The foster family agreed to supervise visits between the youth in care and baby during church services. The youth in care's now former DCFS caseworker told OIG investigators that she and her family spent time with the baby at church, adding the caseworker's daughter was attached to the baby, and the baby would refer to the caseworker as her grandmother. OIG investigators found photos of the baby on the DCFS caseworker's Department-issued cell phone that were taken at the church in March 2021, which was about four months after the DCFS caseworker was no longer assigned to the baby's case. In August 2021, the youth in care told the permanency staff that she did not want any contact with her former DCFS caseworker but was afraid of the repercussions.

RECOMMENDATIONS

1. The caseworker should be disciplined, up to and including discharge, for the following: (a.) failure to report her personal relationship with the youth in care; (b.) falsely identifying members and/or friends of church as fictive kin to the youth in care; (c.) wrongly reporting to various stakeholders that the youth in care had previously unreported mental health disorders that required psychotropic medication – including bipolar disorder and attention deficit hyperactivity disorder (ADHD) – without a diagnosis of such; (d.) failure to provide the youth in care with necessary service referrals, such as for a psychiatric evaluation and substance use disorder services; and (e.) encouraging and facilitating her daughter's involvement in case-related tasks for the youth in care's dependency case.

The Department agrees and has begun the disciplinary process.

2. The permanency supervisor should be counseled for her failure to identify the conflict of interest between the youth in care and the caseworker.

The Department agrees and has begun the disciplinary process.

3. The Department should review the 2019 family case, the youth in care's dependency case, the youth in care's 2020 family case, and April 2020 child protection investigation to correct the following: (a.) The youth in care's noncompliance with medication and mental health services, and (b.) references to the fact that upon leaving the residential facility in April 2020, the youth in care went to a former caregiver's home that she was removed from due to drug use with that caregiver.

The Department agrees. The case will be reviewed to correct the identified service areas.

4. The Department should develop procedures to ensure youth in care who are placed in a private institution, not contracted with the Department, receive a monthly stipend for basic goods and necessities.

The Department agrees. Youth in care will be required to be placed with licensed or contracted organizations. Approval for a non-contracted placement will only be authorized at the Chief Deputy level. The Department will develop procedures to address this issue. Youth placed in a private institution that is not currently contracted with the Department will receive a monthly stipend for basic goods and necessities as part of an approved placement plan.

5. The youth in care should be referred for grief counseling to help cope with the death of her adopted father.

The Department agrees. The youth in care will be referred for grief counseling.

GENERAL INVESTIGATION 5

COMPLAINT A private agency approved a friend of the mother to supervise the mother's visitations with her 8-month-old baby. After seven weeks of this arrangement, the baby returned from a visitation hysterically crying and later tested positive for methamphetamines. Both the mother and her friend were alleged to have had a history of substance use.

INVESTIGATION The Department received a report alleging the then 19-year-old mother was pregnant with the baby and using methamphetamine while the then 23-year-old father used heroin. As the baby was not yet born and the couple had no other children, the Department lacked jurisdiction and could take no further action. Three months later, the Department initiated a child protection investigation after the mother gave birth, and the father showed signs of withdrawal throughout the labor and delivery process. The evening of the baby's birth, law enforcement arrested the father at the hospital for an outstanding warrant. The mother told the child protection investigator that she used methamphetamine for about six months prior to discovering her pregnancy. The Department took protective custody and placed the infant with a maternal relative. The Department indicated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect, and the court awarded custody of the infant to the Department.

The Department referred the family's placement case to a private agency, and the relative foster mother agreed to use her home to supervise the mother's visitations with the baby. The foster mother subsequently told the assigned caseworker that she no longer wanted to supervise visitation at her home and did not feel comfortable supervising visits with the father, who was to be released from prison, in her home. The foster mother also reported concerns about the mother's lack of attention and interaction with the infant during visits. Due to the foster mother's concerns and in accordance with pandemic restrictions, the caseworker arranged for virtual visits. The caseworker planned to utilize a case aide for future in-person visits at the office, but the agency

experienced a case aide shortage. The caseworker's supervisor told OIG investigators that during the pandemic, the agency's program director advised visitations could not be conducted in the office unless there were extenuating circumstances and in office visits required the program director's approval.

In December 2020, the caseworker referred the mother for three toxicology screenings per month, but the mother failed to comply in the first month. The father was also referred for toxicology screenings after his release from prison. The caseworker told OIG investigators that she spoke to the parents after they missed their toxicology screenings, explaining the need to participate in services to have their child returned, and that she was required to report noncompliance to the court. In her January 2021 court report, the caseworker recommended for the parents to engage in parenting classes, counseling, and substance abuse assessments and treatment.

As the placement case continued, the relative foster mother reported concerns about the mother to the caseworker, and the mother reported her relationship with the foster mother was deteriorating. The mother requested that a friend be able to supervise the visits at the parents' home. Following the background check which the friend cleared, the caseworker conducted a home safety checklist at the parents' residence and documented that the parents appeared to be under the influence of drugs while she was at the home. The caseworker also saw the mother's friend at the home and noted she also appeared to be under the influence. The next day, the caseworker sent the parents for a toxicology screening, and the mother tested positive for amphetamines/methamphetamine and the father tested positive for opiates and amphetamines/ methamphetamine. The caseworker told OIG investigators that she had no experience working with clients with substance use issues. The caseworker also stated she told the parents that the friend could not supervise their visits. In her OIG interview, the caseworker stated that Department and private agency staff encourage visits to occur at the parents' residences when the child's permanency goal is return home, and the caseworker did not know she could move visits out of the parents' home. In separate OIG interviews, the caseworker and supervisor reported they did not reassess the appropriateness of the visits at the parents' home or require them to demonstrate sobriety prior to visits with their baby.

The following week, the father entered a 30-day inpatient substance use disorder program as referred from his criminal court case, which he later completed. The caseworker returned to the parents' home approximately seven weeks from when they appeared under the influence; however, this time the caseworker noted almost no concerns during the inspection. The agency approved a different relative to supervise the visitations at the parents' home, and the mother also submitted a request for another friend to supervise the visits, The background check indicated the friend was charged the previous year with possession of a controlled substance and drug paraphernalia, but no convictions. The private agency approved the friend to supervise the visitations.

Over the following month, the mother missed her counseling sessions and toxicology screenings and did not complete a substance abuse assessment. The father also failed to initiate his parenting class, submit to toxicology screenings, or cooperate with his probation, resulting in serving 60 days in county jail. However, before he reported to jail the father was shot in the leg and subsequently hospitalized. The mother told the caseworker that a man attempted to rob the father and shot him. The caseworker attempted to obtain the police records of the incident, but the request was denied because it was an ongoing criminal investigation. In her OIG interview, the supervisor confirmed the denied request for police records and added the agency received a copy of the police report two months later, after the incident of the child testing positive for methamphetamines. The supervisor stated if they had received the report when they initially requested it, they would have learned the police suspected drug involvement during the shooting. The police report also documented the mother admitted to an officer that she and the father used drugs at the home. Local law enforcement informed OIG investigators that law enforcement routinely works with Department child protection investigators and provide reports and information during child protection investigations, but not with private agency staff, stating private agency workers were required to submit a FOIA request for police reports.

In April 2021, the mother's friend began to supervise the visits at the parents' residence. Over the next three weeks, the caseworker and supervisor conducted two unannounced visits to the parents' home to observe the visits and noted no concerns. In the seven months since the placement case opened, this was the first time the caseworker documented observing a visit, and the caseworker told OIG investigators that at that time, she did not know DCFS Procedures required caseworkers to routinely observe visits. Less than three weeks later, the father reported to the county jail. The following week, the caseworker went to the home and informed the mother that the court changed the permanency goal from return home within 12 months to return home pending a status hearing. The caseworker explained to the mother that this change meant she was at risk of losing her child if she did not participate in her services, and the mother stated she would follow through.

The next week, the Department initiated a child protection investigation after receiving a report that the 8-month-old baby tested positive for amphetamines in the emergency room. At the hospital, the child protection investigator spoke to the foster mother, who stated the baby was hysterically crying when the baby returned from a visit with his mother. The foster mother tried to calm the baby for hours and then took him to the emergency room, where the baby tested positive for the drug. The child protection investigator and law enforcement went to the mother's home. The mother denied knowing the cause of the child's exposure, stating she did not have drugs in the home. However, the child protection investigator documented observing drug paraphernalia throughout the home including, a bong, a pill on the floor, a baggie with Narcan, and syringes with one containing brown liquid. When asked about the paraphernalia, the mother admitted to using drugs in the home. The mother reported cleaning the home before the visit but stated the baby may have found something. The mother tested positive for amphetamines/methamphetamines. Law enforcement arrested the mother for endangering the life and health of a child, and the Department indicted her for substance misuse by neglect. During the child protection investigation involving the mother and father, the Department initiated a companion investigation into the friend who supervised the visit and indicated her for inadequate supervision. Eight months later, the court terminated the mother's parental rights, and the father surrendered his rights to the child. The court changed the permanency goal to adoption, and the foster mother committed to adopting the baby.

RECOMMENDATIONS

1. This report should be shared with the private agency for the purpose of training staff on assessment issues in case management as well as the importance of obtaining collateral information from law enforcement.

The Department agrees. The OIG shared the report with the private agency. The DCFS agency performance team monitor will follow-up with the agency to review their plan to address the practice issues outlined in the report.

2. The Department's Division of Clinical Practice's Behavioral Health Substance Use Group should use this report for the development of an informational reference guide for staff on recognizing signs of client substance misuse. The reference guide should also include information for both professionals and non-professionals in a supervisory role during parent child visitation.

The Department agrees. The redacted report was shared with the Deputy of Clinical Practice and the Statewide Administrator of Substance Use and Recovery for review. The Department will develop a reference guide with a target completion date of spring 2023.

GENERAL INVESTIGATION 6

COMPLAINT

A daycare provider was an alleged perpetrator in a child protection investigation and agreed to voluntarily close her daycare pending the outcome of the investigation. However, the provider kept the daycare open creating a risk of harm to children attending the daycare and billed for payments from a childcare resource and referral (CCRR) agency, resulting in an over payment of more than $20,000 to the provider, which the CCRR agency is attempting to recoup.

INVESTIGATION

The Department initiated a child protection investigation into a daycare owner after receiving a report of a 1-year-old child returning home from the daycare with bruising on her face and ears, and a limp arm. A medical specialist diagnosed the child's arm to have a spiral fracture and concluded the injuries were inflicted in an abusive manner within three days of the initiation of the investigation. A child protection investigator interviewed the two sole workers at the daycare, the owner and her assistant, who both denied witnessing injuries on the child that day. Within six days, the daycare owner and assistant turned themselves in and were charged with child endangerment.

Although the daycare owner was named as the alleged perpetrator in the Hotline call, the call floor worker did not mark the intake form to alert the assigned child protection investigator that the report involved a licensed facility which would have prompted the child protection investigator to notify the facility's licensing coordinator, as the child protection investigator and licensing representative must jointly plan their respective investigations and regularly exchange investigative information. The daycare's licensing supervisor did not become aware of the child protection investigation until nine days after the Hotline call, when the daycare owner called the licensing supervisor, informing her of the investigation. The following day, the licensing supervisor initiated a licensing investigation and traveled to the daycare to complete a protective plan to limit contact between the alleged perpetrator and the child victim. Because the child protection investigation involved both daycare workers, the supervisor informed the daycare owner she needed to close the daycare during the child protection investigation. The licensing supervisor told OIG investigators that she carefully reviewed the protective plan with the daycare owner, explaining the daycare's closure during the investigation and that the owner must comply with the licensing worker's weekly monitoring visits to confirm the closure. The supervisor reported the daycare owner seemed cooperative, appeared to understand the explanation, accepted the protective plan, and agreed to close her daycare that same day. However, the daycare owner never closed her daycare instead keeping it open for four months during the child protection investigation. The daycare owner told OIG investigators that she was unaware that by signing the protective plan that she was agreeing to close the daycare.

Less than a week after the daycare owner signed the protective plan to close the daycare, the licensing supervisor sent a copy of the plan to the child protection investigator; however, the child protection investigator had been at the daycare earlier that same day and interviewed some of the children on the premises. In her OIG interview, the child protection investigator disclosed she did not notice the effective date of the protective plan and did not realize the daycare should have been closed when she interviewed the children.

More than three months after the daycare owner signed the protective plan, the licensing worker documented making her first visit to the daycare to monitor the owner's compliance with the plan. Upon arrival to the daycare, the licensing worker called the owner, who declined to allow the worker inside, stating her attorney told her that she did not need to close her daycare during the child protection investigation. The licensing worker told OIG investigators that she did not attempt to assess the daycare from the outside to determine if it was open and operational, as the owner's aggression made her nervous. However, the licensing worker was concerned that the daycare owner could be still caring for children and notified the licensing supervisor of the incident. Three weeks later, the Department indicated the daycare owner and her assistant for physical abuse to the 1-year-old child and substantial risk of physical injury/environment injurious to health and welfare by neglect to three other children in the daycare on the day of the incident. That same day, the child protection investigator informed the licensing supervisor of the completed investigation and that the daycare owner was recently seen

caring for small children. The next day, a different licensing worker made an unannounced visit to the daycare but was not admitted inside and left a monitoring note to remind the owner that she agreed to comply with the protective plan.

The same day as the second licensing visit, the supervisor contacted the local CCRR agency, who confirmed that the daycare owner billed the CCRR for payments despite agreeing to close the daycare four months earlier. The payments were from the Illinois Department of Human Services (IDHS) through its the Child Care Assistance Program (CCAP), in which low-income families apply for subsidized co-payments for childcare. The State's portion of the co-payments are paid to the participating daycare providers through CCRR agencies. The daycare owner reported to her CCRR agency that her daycare cared for 10 children for the four months she was supposed to be closed during the investigation, which totaled over $20,000 for that period. The CCRR agency told OIG investigators that they were not notified of the daycare's closure until the licensing supervisor's call to inquire about the payments. The CCRR agency also stated the only mechanism for the CCRR agency to stop payments is to receive notification from the DCFS licensing workers that a daycare has been closed, but the DCFS has not been consistent in providing this information. After receiving notification of a daycare's closure, the CCRR agency sends notices to the provider and families that the CCRR agency will no longer make payments to the provider and assists the families in finding a new daycare.

The following week, the licensing worker completed a third unannounced visit to the daycare, where she was allowed access to the premises, conducted a walk-through, and saw no evidence of a daycare in operation. The licensing worker told OIG investigators that although the licensing file contained only three documented visits, she did make weekly announced visits to daycare, calling at least a day ahead, and observed no children present. The licensing worker had no explanation as to why the weekly contact notes were absent from the licensing file and the licensing supervisor had no knowledge of the worker making weekly visits.

The licensing supervisor told OIG investigators that there are limited options when providers refuse to comply with protective plans, except to call the provider and attempt to convince them to comply. The supervisor stated she knew of no quick solution to close a daycare, adding the process to revoke or suspend a license is lengthy. However, Department management told OIG investigators that when the daycare provider refused to comply with the protective plan, the licensing worker could have attempted more visits at varying times to see if children were present, called law enforcement to obtain access to the daycare, or sought an administrative order of closure. However, Department management stated the order of closure has never been used during a pending child protection investigation. Department procedures note: "DCFS may issue an administrative order of closure when continued operation of the facility jeopardizes the health, safety, morals, or welfare of children served by the facility." When the Department issues an administrative order, it requires the immediate closure of a licensed daycare, and the Department has 10 working days to revoke or refuse to renew the daycare's license. Licensing staff would compile information regarding the licensing investigation and reason immediate closure was necessary and obtain required approval from the deputy director of licensing and the director. The Department procedures do not specify if the Department can issue an administrative order of closure during a child protection investigation.

RECOMMENDATIONS

1. The Department should ensure CCWIS includes a mechanism for direct notification to licensing of a child protection investigation involving a facility.

The Department agrees. The recommendation will be incorporated in the new CCWIS. In the meantime, the Division of Child Protection is editing the CANTS 21 form, *Notification of Child Abuse or Neglect Investigation in a Licensed Foster Home or Facility*, to be used in all facility reports-licensed or unlicensed. In addition, at Child Protection Statewide Meetings for supervisors and area administrators, the need for child protection to notify licensing at the onset of any facility report-licensed or unlicensed has been emphasized.

2. The Department should review and clarify the use of an administrative order of closure during a pending child protection investigation.

The Department agrees. Use of an administrative order of closure during a pending child protection investigation was reviewed with new daycare Licensing staff in September 2022 and all existing daycare licensing staff received a refresher training on Procedures 383, *Licensing Enforcement* in December 2022, which included instruction on the use of an administrative order of closure during a pending child protection investigation.

3. The Department should develop procedures for notifying the local Illinois Department of Human Services (IDHS) Child Care Assistance Program when a protection plan is implemented, and a daycare is temporarily voluntarily closed. The Department should also immediately notify IDHS Childcare Assistance Program of a change in the status of the protection plan for the daycare facility.

The Department agrees. Procedures 383.45, *Protective Plan,* will be revised to require that Day Care Licensing staff notify the local IDHS Child Care Assistance Program when a signed receipt of a protection plan that requires a daycare's temporary voluntary closure is issued and when and if the day care is reinstated. In addition, IDHS will be informed that they may need to review childcare payments in the event of a temporary voluntary closure.

4. The Department should share this report for training and discussion purposes with the Deputy Director of the State Central Register, the Deputy Director of Daycare Licensing, and the Assistant Deputy Director of Daycare Licensing.

The Department agrees. The report has been shared and discussed with the involved staff.

GENERAL INVESTIGATION 7

COMPLAINT A Department employee fraudulently claimed she was on state business and used her Department employee credentials in an attempt to obtain discounted state government official travel rates from an out-of-state hotel.

INVESTIGATION According to hotel records, the Department employee selected the discounted state government employee rate when she booked two rooms for three days through the out-of-state hotel's website. Per the hotel's policy, the state government rate did not apply to out-of-state employees not conducting official state business. Prior to the Department employee's arrival, the hotel staff informed the employee of this policy, stating to qualify for the discounted rate, the employee would need to present a government employee ID from that state and a document authorizing travel for official government business. The hotel staff stated to OIG investigators that the Department employee agreed to fulfill these requirements, but that the employee attempted to check in to the hotel by providing her Illinois Department ID and a letter on Department letterhead that she had signed herself. Hotel staff informed the Department employee that she did not qualify for the state government rate. The Department employee made multiple attempts to receive the discounted rate by telling different hotel staff that she was there for official state business.

The Department employee stated that prior to arriving at the hotel, hotel staff informed her that she needed to provide proof that she was a state employee because she had made the reservation under the discounted state government rate. During the OIG interview, the employee told OIG investigators that she stayed at the hotel while on vacation and denied she told hotel staff that she was conducting official state business.

The Department employee's persistence in fraudulently claiming she was on state business to receive a reduced rate for hotel rooms violated the standards of professional conduct required of Department employees. Department employees are in a position of public trust and are prohibited from participating in dishonest behavior and from misrepresenting their duties and professional credentials.

RECOMMENDATIONS

1. The Department should take appropriate disciplinary action against the employee for misuse of her DCFS authority and violating the principles of professional conduct.

The Department agrees. The employee was issued an oral reprimand.

GENERAL INVESTIGATION 8

COMPLAINT

A Department administrator interfered in a pending child protection investigation of a family with whom the administrator had a personal familial relationship. It was also alleged that the administrator was improperly provided access to the child protection investigation access in SACWIS.

INVESTIGATION

A report was made to the Hotline regarding the safety of a 2-year-old child who was under the care of her father. The reporter stated the father found the mother deceased earlier that day, and the reporter believed the father was responsible for her death due to prior domestic incidents. The reporter also alleged the paternal family members were receiving confidential information about the investigation from the administrator. The assigned child protection investigator contacted the reporter, who stated the administrator was a family friend of the father's and was interfering with the child protection investigation. The Department reassigned the investigation to a child protection investigator outside of the administrator's jurisdiction and restricted access to the investigation records by reclassifying the investigation in SACWIS.

The reporter who alleged the administrator interfered with the investigation was unable to provide any specific reasons or information regarding the allegation to OIG investigators, except that the administrator worked for the Department and was a family friend of the father. OIG investigators also interviewed the child protection investigator under the administrator's jurisdiction who was originally assigned to the investigation, and she stated he was never contacted by nor spoke to the administrator about the investigation. Lastly, OIG investigators contacted the deputy coroner and police officer assigned to the mother's case, as well as the mother's neighbor, and they all reported having no recollection of speaking to nor being contacted by the administrator.

Analysts from the DCFS Office of Information Technology Service (OITS) and Department of Information Technology (DoIT) were asked to review the administrator's activity in SACWIS to determine if the administrator accessed the investigation records. The analysts found that approximately two weeks after the investigation was reassigned, the administrator's security access level in SACWIS was changed so the administrator could view additional investigations outside of her jurisdiction. DoIT staff found that the change was made by a child protection supervisor who was not within the administrator's jurisdiction.

However, the OIG investigators found the change to the administrator's access level did not allow the administrator to access records for that particular investigation. The supervisor most likely mistakenly changed the administrator's access level when the supervisor attempted to have the administrator review a different and

unrelated child protection investigation as per normal operations. OIG investigators found that the administrator and supervisor worked in different regions of the state, there was no evidence of a personal relationship between the administrator and child protection supervisor nor any motive for the supervisor to grant the administrator the enhanced security access in SACWIS.

The ability to change access levels in SACWIS was intended to be limited to two specific OITS/DoIT employees. However, the supervisor's ability to change the access levels in SACWIS was due to a programing error that allowed Department employees in a supervisory or higher positions to change the access level. This also meant that the administrator did not need the supervisor to change her access in SACWIS, because the administrator could have granted herself the change at her current security level. If the system had worked correctly, the supervisor would never have been able to change the access levels. This programing error was corrected, and only the two specific OITS/DoIT employees can change the access levels in SACWIS.

RECOMMENDATIONS

1. This report should be shared with the administrator's supervisor.

The Department agrees. The report was shared.

DEPARTMENT UPDATE ON PRIOR SYSTEMIC RECOMMENDATIONS

The Office of Inspector General's systemic recommendations are designed to strengthen the child welfare system to better serve children and families. The OIG tracks and monitors the implementation of recommendations accepted by the Department. The following systemic recommendations were made in prior fiscal years and were pending when last year's OIG Annual Report was issued. The Department's current implementation status is detailed below in the following categories:

- **CHILD PROTECTION**
- **COMPREHENSIVE CHILD WELFARE INFORMATION SYSTEM (CCWIS)**
- **DOMESTIC VIOLENCE**
- **INTACT FAMILY SERVICES**
- **MENTAL HEALTH**
- **PERSONNEL**
- **SERVICES**

CHILD PROTECTION

FY 2021

The Department should amend Procedures 300, Appendix B, Allegation of Harm #79-Medical Neglect to include the following required activity, "If a child has special health care needs, as defined in Procedures 302, Appendix O, Referral for Nursing Consultation Services, the Child Protection Specialist must complete a DCFS nurse referral." (from OIG FY 2021 Annual Report, Death and Serious Injury Investigation 1).

FY 2022 Department Update: Allegation #79, *Medical Neglect* is in the process of being revised. The recommendation will be incorporated in the revisions to procedures.

FY 2021

The Department should incorporate the Subsequent Oral Report Memo into Procedures 300, *Reports of Child Abuse and Neglect* (from OIG FY 2021 Annual Report, Death and Serious Injury Investigation 6).

FY 2022 Department Update: The Department issued Policy Transmittal 2022.07, *Procedures 300 and CANTS 33* on September 9, 2022. New subsections from the SOR memo were added to Procedures 300.50 that outline specific activities that need to be undertaken with each child protection investigation including: Section 300.50(a) titled "Required Activities Prior to Initiating Contact with Subject of Report," which details the use of the SBAR (Situation, Background, Assessment/Analysis, Recommendation) tool, required pre-commencement activities, and the formation of an Initial Investigative Plan; and Section 300.50(b) titled "Offering of Voluntary Intact Family Services," which details the assessment process for Intact Family Services. The updates to Procedures 300 provide clear direction on the use of a family's prior history

to inform and direct investigative activities. The updates to Procedures 300 were reviewed in 9 subregional in person meetings with Child Protection Supervisors, Area Administrators and Regional Administrators.

FY 2021

Child protection investigations initiated within six months after the closure of the family's placement or intact family services case should require heightened review and consultation from the child protection Area Administrator (from OIG FY 2021 Annual Report, Death and Serious Injury Investigation 9).

FY 2021 Department Response: The Department agrees. Child Protection and the Office of Legal Services are currently incorporating the subsequent oral report memo into Policy and Procedure.

FY 2022 Department Update: The Department agrees that heightened review must occur when making a final determination on an investigation that occurs w/in 6 months of the closing of an intact report. In September of this year, in order to best provide investigators and supervisors with clear direction on how to use critical thinking in every step of investigations, the Department released significant updates to Procedures 300 that include required pre-commencement activities and complete analysis of the Situation and Background in every decision throughout the investigation. The Department believes that building the critical thinking at the worker and supervisor level is the best mechanism to achieve safety in these cases. We believe the recommendation of close scrutiny is achieved at the worker/PSA level, and not by adding an additional task to Area Administrator requirements. The division of child protection will continue to evaluate this approach, make it a point of emphasis between Area Administrators and supervisors and make future adjustments to the heightened review process as needed.

FY 2021

In the absence of the Public Service Administrator, only the Child Protection Advanced Specialist or Area Administrator should be allowed to approve a Child Endangerment Risk Assessment Protocol and/or provide a Final Supervisory Decision (from OIG FY 2021 Annual Report, Death and Serious Injury Investigation 6).

FY 2022 Department Update: The Department has selected a new safety decision tool to replace the Child Endangerment Risk Assessment Protocol (CERAP) and the implementation planning is underway.

FY 2021

The Department must ensure that investigative teams have the resources to adequately execute the requirements outlined in the February 2020 Subsequent Oral Reports memo (from OIG FY 2021 Annual Report, Death and Serious Injury Investigation 7).

FY 2022 Department Update: The Department issued Policy Transmittal 2022.07, *Procedures 300 and CANTS 33* on September 9, 2022. New subsections were added to Procedures 300.50 that outline specific activities that need to be undertaken with each child protection investigation including: Section 300.50(a) titled "Required Activities Prior to Initiating Contact with Subject of Report" which details the use of the SBAR (Situation, Background, Assessment/Analysis, Recommendation) tool, required pre-commencement activities, and the formation of an Initial Investigative Plan; and Section 300.50(b) titled "Offering of Voluntary Intact Family Services" which details the assessment process for Intact Family Services. The updates to Procedures 300 provide clear direction on the use of a family's prior history to inform and direct investigative activities. The updates to Procedures 300 were reviewed in 9 subregional in person meetings with Child Protection Supervisors, Area Administrators and Regional Administrators.

FY 2021

The Office of Learning and Professional Development should review Foundations Training for child protection and incorporate training material on the use of a family's prior history to assess risk (from OIG FY2021 Annual Report, Death and Serious Injury Investigation 6).

FY 2022 Department Update: The Department issued Procedure including Required pre-commencement activities that include clear direction on the requirement and steps to fully evaluate prior history. The Chief Deputy Director of Child Protection and SCR along with the Deputy of Child Protection met with the Deputy and every trainer in the Office of Learning and Professional Development and provided training on this new procedure and how to train new hires on this important investigative function.

FY 2021

The Department should establish procedures for developing and monitoring care plans during child protection investigations and for informing parents of their rights in the event a care plan is put in place (from OIG FY 2021 Annual Report, General Investigation 7).

FY 2022 Department Update: The Department agrees and is in the process of implementing a new Safety Decision Tool called the SAFE Model, that addresses this very issue by including a mechanism to ensure the safety of children when absent a determination of "UNSAFE" but there is an agreement by the family to make 'care plans' formally.

FY 2021

In child protection investigations involving facility reports in which biological children are involved, the Department should modify procedures/SACWIS to allow the Child Endangerment Risk Assessment Protocol to be conducted on the biological/adopted children (from OIG FY2021 Annual Report, General Investigation 7).

FY 2022 Department Update: The Department has selected a new safety decision tool to replace the Child Endangerment Risk Assessment Protocol (CERAP), and the implementation planning is underway.

FY 2020

The Department should communicate a more consistent application of "blatant disregard" to child protection staff (from OIG FY 2020 Annual Report, Death and Serious Injury Investigation 5).

FY 2022 Department Update: The recommendation was addressed in a Practice Memo dated November 16, 2022, that was shared with Child Protection staff, the Office of Learning and Professional Development staff, Regional Administrators and Area Administrators with the direction to share at the team and worker level. Additionally, to ensure consistent application of "blatant disregard" where there is a sleep related death, the Department has updated Procedure 300.75 requiring the Area Administrator to send reports to the Associate Deputy Director of Child Protection for review. This update is currently with the Office of Child and Family Policy.

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 2022 Department Update: The recommendation has been incorporated in the draft of Procedures 300.80, *Child Protection Supervisor/Area*. This procedural update is currently pending finalization with the Office of Child and Family Policy.

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 2022 Department Update: The Department has selected a new safety decision tool to replace the Child Endangerment Risk Assessment Protocol (CERAP), and the implementation planning is underway.

COMPREHENSIVE CHILD WELFARE INFORMATION SYSTEM (CCWIS)

FY 2021

When child protection investigators or caseworkers discover a video posted on social media that depicts the family engaging in behavior that is dangerous to the welfare or safety of minors within the household, the investigator or caseworker should immediately make a copy of that video before the video can be removed from social media. The CCWIS committee should ensure that the Department's new data system is able to accommodate social media files (from OIG FY2021 Annual Report, Death and Serious Injury Investigation 9).

FY 2022 Department Update: The recommendation will be incorporated in the new CCWIS. The Department will ensure the new system is able to store multimedia files, including video, as part of the intake, investigation, case, expenditure, or persons and will investigate the feasibility of recording media from various social media platforms.

FY 2021

There should be an automatic electronic notification process to notify the Area Administrator where there is physical abuse to a child under 3, and the Area Administrator must review the case prior to closure (from OIG FY2021 Annual Report, Death and Serious Injury Investigation 3).

FY 2022 Department Update: The recommendation will be included as part of the functional design requirements in the new CCWIS. In the meantime, the Area Administrators get a weekly report of the children under age 3 and are required, per procedure, to document their assessment at the time of the safety decision.

FY 2020

DCFS should ensure that the new CCWIS has an indicator to alert SCR 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 (from OIG FY 2020 Annual Report, General Investigations 2).

FY 2022 Department Update: The recommendation will be incorporated in the new CCWIS. The Department will ensure there is an indicator to alert State Central Register staff when a subject in a Hotline report has had their parental rights terminated. In addition, a request has been submitted to the Department of Technology and Innovation (DOIT) to ensure SCR staff are alerted when a subject in a Hotline report has had their parental rights terminated.

FY 2020

With the development of the new CCWIS program the Department should request that the program be able to track the CANTS and LEADS searches of individual users (from OIG FY 2020 Annual Report, General Investigations 3).

FY 2022 Department Update: The recommendation will be incorporated in the new CCWIS. The Department will ensure that the new system tracks CANTs and LEADs searches of individual users.

FY 2020

The Department should ensure that SACWIS and/or the new CCWIS has all previous history of individuals linked to that person and accessible from clicking on the person's name (from OIG FY 2020 Annual Report, General Investigations 4).

FY 2022 Department Update: The recommendation will be incorporated in the new CCWIS.

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 2022 Department Update: The recommendation will be incorporated in the new CCWIS.

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 2022 Department Update: The Department will ensure that newborn genetic metabolic screens are accessible in the new CCWIS.

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 2022 Department Update: Policy Transmittal 2022.03, *Procedures 300-Appendix J (Domestic Violence)* was issued on June 6, 2022.

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 2022 Department Update: Policy Transmittal 2022.03, *Procedures 300-Appendix J (Domestic Violence)* was issued on June 6, 2022.

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 2022 Department Update: Policy Transmittal 2022.03, *Procedures 300-Appendix J (Domestic Violence)* was issued on June 6, 2022.

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 2022 Department Update: Policy Transmittal 2022.03, *Procedures 300-Appendix J (Domestic Violence)* was issued on June 6, 2022.

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 2022 Department Update: Policy Transmittal 2022.03, *Procedures 300-Appendix J (Domestic Violence)* was issued on June 6, 2022.

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 2022 Department Update: Policy Transmittal 2022.03, *Procedures 300-Appendix J (Domestic Violence)* was issued on June 6, 2022.

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 2022 Department Update: Policy Transmittal 2022.03, *Procedures 300-Appendix J (Domestic Violence)* was issued on June 6, 2022.

INTACT FAMILY SERVICES

FY 2021

As previously recommended in a prior Inspector General investigation, a 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 medical care. OIG reiterates this recommendation and as noted in the previous Annual Report, acknowledges that the Department is working on its implementation (from OIG FY2021 Annual Report, Death and Serious Investigation 2).

FY 2022 Department Update: The following language was incorporated in draft Procedures 302.388, *Intact Family Services*: Within one week of case opening, convene a phone conference with the assigned DCFS Regional Nurse, if there is already one assigned and the referral is still open, or make the appropriate referral to have a DCFS Regional Nurse assigned; Convene a Child and Family Team Meeting within 10 working days of case opening that specifically addresses the oversight and responsibilities of the caregivers of medically complex children; Convene a staffing, within 30 days of receiving the case, with the medical case manager, home health care provider, and parent(s) to discuss the child's care and assess parent's needs for tangible and emotional support. The draft procedures are pending finalization with Office of Child and Family Policy.

FY 2021

Policy Guide 2020.16, Procedures 302.388, Intact Family Services, noted that revisions to Procedure 302, Appendix O, Referral for Nursing Consultation Services, would be forthcoming. As such, this report should be shared with the committee tasked with revising Rules and Procedures 302, Appendix O (from OIG FY2021 Annual Report, Death and Serious Investigation 2).

FY 2022 Department Update: The following language was incorporated in draft Procedures 302.388, *Intact Family Services,* Contact or make a referral to the DCFS Regional Nurse as outlined in Appendix O and consult with the nurse as needed when there is a medical emergency. The draft procedures are pending finalization with Office of Child and Family Policy.

FY 2021

The Department should review the referral process for Intact Family Services. As this case demonstrates, the timeliness of referrals is an issue, and the referral process is not adequately monitored or enforced. The Department's review of the referral process should address streamlining the process by deleting duplicative or unnecessary steps, delineating a clear path of administrative review to ensure timely referrals, and assessing barriers to referrals (from OIG FY2021 Annual Report, Death and Serious Injury Investigation 4).

FY 2022 Department Update: The Department has implemented a new referral process for intact family services to ensure timeliness in the referral process. The new process is currently being followed and has been incorporated in draft procedures 302.388, *Intact Family Services* which is being finalized by the Office of Child and Family Policy.

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 2022 Department Update: The following language was incorporated in draft Procedures 302.388, *Intact Family Services*: Within one week of case opening, convene a phone conference with the assigned DCFS Regional Nurse, if there is already one assigned and the referral is still open, or make the appropriate referral to have a DCFS Regional Nurse assigned; Convene a Child and Family Team Meeting within 10 working days of case opening that specifically addresses the oversight and responsibilities of the caregivers of medically complex children; Convene a staffing, within 30 days of receiving the case, with the medical case manager, home health care provider, and parent(s) to discuss the child's care and assess parent's needs for tangible and emotional support. The draft procedures are pending finalization with Office of Child and Family Policy.

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 2022 Department Update: The recommendation was incorporated in Policy Guide 2020.16, *Intact Family Services* and issued on November 20, 2020. The recommendation has also been incorporated in draft Procedures 302.388, *Intact Family Services.* The draft procedures are pending finalization with Office of Child and Family Policy.

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 2022 Department Update: The following language was incorporated in draft Procedures 302.388, *Intact Family Services*: Within one week of case opening, convene a phone conference with the assigned DCFS Regional Nurse, if there is already one assigned and the referral is still open, or make the appropriate referral to have a DCFS Regional Nurse assigned; Convene a Child and Family Team Meeting within 10 working days of case opening that specifically addresses the oversight and responsibilities of the caregivers of medically complex children; Convene a staffing, within 30 days of receiving the case, with the medical case manager, home health care provider, and parent(s) to discuss the child's care and assess parent's needs for tangible and emotional support. The draft procedures are pending finalization with Office of Child and Family Policy.

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 2022 Department Update: The DCFS Child Protection Training Academy at Northern Illinois University and a simulation training academy at Southern Illinois University will open in early 2023. Intact will be a priority population for both new simulation centers once they begin to provide trainings.

MENTAL HEALTH

FY 2021

The Department should update the CFS 968-90, Questions for Mental Health Professionals form for intact family services and provide guidance to intact staff on the use of the form (from OIG FY2021 Annual Report, Death and Serious Injury Investigation 1).

FY 2022 Department Update: Policy Transmittal 2022.11, *Procedures 300.50,* was issued on September 27, 2022, to inform staff that effective immediately Procedure 300.50, *Investigative Process*, and form CFS968-90, *Questions for Mental Health Professionals* have been amended. The form can now be used by the divisions of child protection, intact family services and permanency.

FY 2021

The Department should develop a referral form, similar to the CANTS 65-A, Referral Form for Medical Evaluation of a Physical Injury to a Child, that is specific to allegations of medical neglect (from OIG FY2021 Annual Report, Death and Serious Injury Investigation 1).

FY 2022 Department Update: Policy Transmittal 2022.08, *P300.100 and CANTS 65-B* was issued on September 9, 2022, to inform staff of changes to Procedure 300.100, *Medical Requirements for Reports of Child Abuse and Neglect*, and the implementation of form CANTS 65-B, *Evaluation of Medical Neglect of a Child*. The changes to Procedure 300.100 include action that Child Protection Specialists must take with regards to medical evaluations and care when investigating reports of abuse or neglect. The updates to Procedures 300 were reviewed in subregional in-person meetings with Child Protection Supervisors, Area Administrators and Regional Administrators.

FY 2021

As previously recommended in a prior Inspector General investigation, the Department should develop a form similar to the CFS968-90, Questions for Mental Health Professionals to be utilized by child protection staff when interviewing mental health professionals regarding an alleged perpetrator (from OIG FY2021 Annual Report, Death and Serious Injury Investigation 1).

FY 2022 Department Update: In collaboration with the Clinical Division, DCFS Medical Director, and Child Protection Division, Policy Transmittal 2022.11, *Procedures 300.50,* was issued on September 27, 2022, to inform staff that effective immediately Procedure 300.50, *Investigative Process*, and form CFS968-90, *Questions for Mental Health Professionals* have been amended. The form can now be used by the divisions of child protection, intact family services and permanency.

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 2022 Department Update: In collaboration with the Clinical Division, DCFS Medical Director, and Child Protection Division, Policy Transmittal 2022.11, *Procedures 300.50,* was issued on September 27, 2022, to inform staff that effective immediately Procedure 300.50, *Investigative Process*, and form CFS968-90, *Questions for Mental Health Professionals* have been amended. The form can now be used by the divisions of child protection, intact family services and permanency.

PERSONNEL

FY 2021

The Office of Employee Services and the Child Welfare Employee Licensure Unit should develop and implement a process to ensure Child Welfare Employee License verification prior to making an offer of employment to a candidate for a position requiring a Child Welfare Employee License (from OIG FY2021 Annual Report, General Investigations 6).

FY 2022 Department Update: The Office of Employee Services developed a process for verification of an applicant's Child Welfare Employee License. In addition, additional screening questions related to the applicant's CWEL was added to the CFS-717H, *preliminary hire form for candidates.*

FY 2021

Department procedures should be amended to provide that licensing complaint investigations involving DCFS workers should be conducted by personnel from a different field office (from OIG FY2021 Annual Report, General Investigation 10).

FY 2022 Department Update: The recommendation was incorporated in changes to Procedures 437.40, *Segregation of Duties* which was issued July 5, 2022.

FY 2020

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 (from OIG FY 2020 Annual Report, General Investigation 13).

FY 2022 Department Update: The Divisions of Licensing, Permanency and the Office of Legal Services will convene a workgroup and will have a final policy recommendation on or before January 31, 2023.

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 2022 Department Update: DCFS Labor Relations and the Office of Employee Services (OES), in conjunction with Payroll, created a form and timekeeping process to document temporary assignments. The form is to be completed by the requesting employee and their supervisor and returned to Labor Relations/ OES for tracking and sign-off. Once approved, a copy is sent to Payroll as well as the requesting employee and supervisor for their records. This new process and form will remain in place until the new time keeping system (ERP/Human Capital Management Project) has officially been implemented, which is tentatively expected to occur between 2023-2024.

SERVICES

FY 2021

The Department must review Procedures 307, Indian Child Welfare Services, to ensure compliance with the 2016 federal rule regarding the Indian Child Welfare Act (from OIG FY2021 Annual Report, General Investigation 5).

FY 2022 Department Update: The Division of Diversity, Equity and Inclusion will work with the Division of Child and Family Policy to review Procedure 307 and address the recommendation in 2023.

FY 2020

The Department should issue a policy memo clarifying the process for determining foster home capacity based on Rule 402, *Licensing Standards for Foster Family Homes*, Appendix C and should be consistent with placement clearance desk procedures (from OIG FY 2020 Annual Report, Death and Serious Investigation 7).

FY 2022 Department Update: Rule 402–Non-Safety Standards Training is now available on the Virtual Training Center (VTC) as of August 15, 2022. The training covers expanded capacity and directed staff to Rule 402 and Appendix B, and C, which provides a break-down of how to determine capacity. In addition, the Office of Child and Family Policy will issue an information transmittal informing staff of the available training.

FY 2020

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 (from OIG FY 2020 Annual Report, General Investigations 11).

FY 2022 Department Update: A policy transmittal was drafted and submitted to the Office of Child and Family Policy to finalize the process for foster home licensing staff to designate a foster home as a Spanish-speaking home.

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 2022 Department Update: Representatives from the Division of Permanency, the Guardian's Office, Office of Child and Family Policy and Office of Legal Services met on November 21, 2022 to determine whether a court order should be required to disallow biological parents access to electronic educational records. The results of this meeting will be shared with Illinois State Board of Education (ISBE) at a later date to establish Illinois' policy, practice and procedure related to parental access to educational records.

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 2022 Department Update: The Child Welfare Advisory Committee has established a subcommittee to address an improved reunification training.

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 2022 Department 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 2022 OIG Comment:* This recommendation has been pending for 5 years. Given the broad use of social media in our society this recommendation continues to be relevant and has a direct impact on how front-line staff can effectively execute their job duties.

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 2022 Department Update: The Child Welfare Advisory Committee has established a subcommittee to address an improved reunification training.

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: 2022 IG 1073
Subject: Delay in Seeing Children Cluster Report

SUMMARY OF COMPLAINT

The Office of the Inspector General (OIG) investigates child deaths 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 and investigates complaints from DCFS employees and the general public. During the OIG's review of complaints and child deaths from FY 20 through FY 22, the OIG identified a systemic pattern of child protection investigations where there was a significant delay in child protection investigators making initial contact with the child(ren) after a Hotline call. These child protection investigations are detailed below.

INVESTIGATIONS

The following FY 20 through FY 22 OIG investigations were included in this cluster report due to the presence of a significant delay in child protection investigators making initial in-person contact with the alleged child victim(s) after a report to the Hotline.

#	OIG Case Number	Child Protection Investigations-SCR	Days until contact	County
1	2022-0564	1C	29	County A
2	2021-3556	2A	52	County B
3	2022-0697	3A	59	County C
4	2022-0642	4F	92	County B
5	2022-0672	5C	69	County B
6	2021-2934	6C	41	County B
7	2022-0471	7E	60	County A
8	2022-0844	8A[1]	50	County B
9	2022-0443	9A	76	County B
10	2022-0603	10A	42	County A
11	2020-0698	11E	52	County D
12	2022-0826	12F	50	County B
13	2022-1038	13A	63	County B
14	2022-1006	14A	123	County A

[1] Companion report (SCR# 23C) was also opened and investigated at the same time as SCR# 8A.

15	2022-1267	15B	62	County B
16	2022-1293	16A	27	County B
17	2021-1853	17B	44	County B
18	2022-0193	18E	123	County E
19	2021-0069	19A	53	County F
20	2022-0913	20A	223 and 303	County G
21	2022-0622	21A	36	County B
22	2021-3154	22A	131	County B
23	2021-3154	22B	59	County B
24	2021-3154	22C	64	County B

The following are summaries of the attempts that the child protection investigators made to locate and see the alleged child victim(s) during the child protection investigations.

1. OIG Case 2022-0564
SCR #1C (08/22/2021 – 10/21/2021) Indicated
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to 2-year-old by mother and father
Ages of children in the home: 2 and 13 years old
Days until contact: 29

On August 22, 2021, a mandated reporter contacted the Hotline to report the mother left work with a friend and her child's father followed them. The father became upset and started hitting the vehicle window with his fist and elbow in an attempt to break the car window. The father threatened to kill the mother and her friend, then left with their 2-year-old child. DCFS opened an investigation for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to the 2-year-old by her mother and father.

That same day, the on-call worker went to the home, but no one answered the door. The child protection investigator left her business card.

The next day, August 23, 2021, the case was assigned to another child protection investigator. The child protection investigator did not document any attempts to interview the family until after the child's death. The Hotline was contacted on September 11 to report the accidental drowning of the 2-year-old, but the child protection investigator did not interview the mother and surviving sibling until nine days after the death.

On October 21, 2021, DCFS indicated the investigation for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect against the father, and unfounded the investigation against the mother.

2. OIG Case 2021-3556
SCR #2A (12/14/2020 – 02/11/2021) Unfounded
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to 5-year-old by mother
Allegation #74d-Inadequate Supervision - General Category to 5-year-old by mother
Allegation #77-Inadequate Shelter to 5-year-old by mother
Ages of children in the home: 2, 5, 7, 9, 10, 14, 16 and 17 years old
Days until contact: 52

On December 14, 2020, the Hotline received a call alleging there were four or five children under the age of 7 living in the home that had a large picture window broken because of a shooting months earlier and the window was being covered by a sheet. The reporter provided an address but did not know the names of the children. The report was taken for investigation of allegations #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect, #77-Inadequate Shelter, and #74d-Inadequate Supervision - General Category.

The next day, the child protection investigator documented a good faith attempt to the address provided in the Hotline narrative, but no one was home. The child protection investigator left her business card in the mailbox. There were no other documented attempts until February 1, 2021, when the child protection investigator conducted a diligent search to locate the family, which produced another possible address. The child protection investigator mailed a letter to that address.

On February 2, 2021, the supervisor documented that she instructed the child protection investigator to make another attempt to see the family. The following day, February 3, the child protection investigator made a good faith attempt to see the family at the address found in the diligent search, but no one was home. The child protection investigator documented that she did not observe a broken window during the attempt.

On February 4, 2021, the child protection investigator went to the address originally reported to the Hotline; this was her second documented attempt to this address. She met with the mother and the eight children. The child protection investigator observed the broken window covered with a sheet, but the family denied that it was due to a shooting. Seven days later, DCFS closed and unfounded the investigation.

3. OIG Case 2022-0697[2]
SCR #3A (09/15/2020-02/12/2021) Unfounded
Allegation #19-Sexual Penetration to 6-year-old by mother's paramour
Ages of children in the home: 1, 3, and 6 years old
Days until contact: 59

On September 15, 2020, a mandated reporter contacted the Hotline to report a 6-year-old child disclosed to her great grandmother that her stepfather had sexually abused her. The report was taken for investigation. Law enforcement personnel requested that DCFS not contact the alleged perpetrator, as officers planned to conduct interviews with the three children, including the 6-year-old, prior to contacting the stepfather.

[2] On June 17, 2022, the OIG issued a full investigative report on this case.

DCFS opened an investigation for allegation #19-Sexual Penetration to the 6-year-old child by the mother's paramour.

The next day, September 16, 2020, the child protection investigator spoke with the child's great-grandmother. She documented a good faith attempt to see the children at the home of the great-grandmother who informed the child protection investigator the children were at school and daycare.

The child protection investigator documented that on September 18, 2020, she received a phone call from the mother who was inquiring as to when the children's forensic interviews at the CAC would be scheduled. No other detail was provided in the contact note as to whether the interview would be scheduled.

On September 24, 2020, the supervisor instructed the child protection investigator to make two more attempts to see the victim, and then send a letter to the home. The next documented case note was another supervisory consultation dated October 23, instructing the child protection investigator to contact law enforcement for additional information.

On November 13, 2020, two months after the initial Hotline call, the child protection investigator documented the next attempt to see the children. The child protection investigator observed the alleged child victims at the home of their great-grandmother and interviewed their mother. When the child protection investigator interviewed the 6-year-old child, she recanted the allegations that she made against her stepfather. A forensic interview was never conducted.

On February 11, 2021, DCFS closed and unfounded the investigation for allegation #19-Sexual Penetration due to insufficient evidence.

4. OIG Case 2022-0642

SCR #4F (07/21/2021-11/05/2021) Indicated
Allegation #74a-Inadequate Supervision - Left Alone at Home, Outside or in the Community to all seven children by mother
Allegation #82-Environmental Neglect to all seven children by mother
Ages of children in the home: 2, 4, 5, 6, 8, 11, and 14 years old
Days until contact: 92

On July 21, 2021, a mandated reporter contacted the Hotline to report that when she arrived at the family's home, she found the seven children home alone after their mother left to pick the oldest child up from summer camp. The reporter also noted a broken window and clothing all over the home. The investigation was opened for allegations #74a-Inadequate Supervision - Left Alone at Home, Outside or in the Community and #82-Environmental Neglect.

The next day, the mandate investigator made a good faith attempt to see the children and documented that no one answered the door. Her assignment to the investigation ended the same day.

No other attempts were made to see the family until over six weeks later. On September 13, 2021, the assigned intact caseworker contacted the assigned child protection investigator to inform her that she found the 2- and 4-year-old children home alone. The intact worker informed the child protection investigator that the police were called, but no arrests were made.

The same day, the child protection investigator documented that upon arrival to the home, she contacted the mother by phone, and the mother reported that she was in traffic and unsure when she would return

home. The child protection investigator instructed the mother to contact her when she arrived home. Later the same day, the child protection investigator documented that she went to the home, but the mother refused to allow the investigator into the home. While at the home, the child protection investigator attempted to contact the intact caseworker by phone but had to leave a voicemail. The child protection investigator contacted the police department. When police arrived, the mother still refused to allow access to the home or the children. The next day, the supervisor instructed the child protection investigator to contact the assigned intact worker and schedule a joint visit to the home.

Twenty-three days later, on October 7, 2021, the child protection investigator sent an email to the intact worker with the following message, "Can you please let me know the next time that you are visiting again next week in the home. I need to make another effort to see the children." On October 14, the child protection investigator documented mailing a letter to the mother.

On October 18, 2021, the Hotline was contacted to report the death of a family friend, a 4-month-old. The mother of the seven children had been caring for the infant, and therefore SCR #4G was opened to investigate the infant's death.

The next day, the supervisor instructed the child protection investigator to contact the investigator assigned to the death investigation and coordinate contacting the mother and children in the home.

Later the same day, three months after the initial Hotline call, the child protection investigator made an unannounced visit to the home with the investigator for the death investigation and the family's intact caseworker. When they arrived at the home, six of the children, ages 2, 4, 5, 6, 8 and 11 years, were home alone. The mother arrived approximately 40 minutes later. Protective custody was taken of all seven minors.

On November 5, 2021, DCFS closed and indicated the investigation against the mother for allegations #82-Environmental Neglect and #74a-Inadequate Supervision - Left Alone at Home, Outside or in the Community. DCFS unfounded the death investigation against the mother.

5. OIG Case 2022-0672

SCR #5C (08/11/2021-11/06/2021) Indicated
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to both children by mother
Ages of children in the home: 7 months old and 8 years old
Days until contact: 69

On August 10, 2021, a mandated reporter contacted the Hotline to report that the mother lived with her two children, a 7-month-old infant and an 8-year-old child, in a shelter. The mother was in a drug treatment program, through which she was prescribed medication, but the reporter suspected the mother was also taking street drugs. The reporter stated that the mother and her children had been living in a homeless shelter. The reporter stated concerns that the mother breastfed her baby and the baby screamed all night. The reporter also stated that the mother exhibited erratic behaviors while caring for the children. The investigation was opened for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect.

The next day, the child protection investigator attempted to see the family at the shelter. The child protection investigator rang the doorbell and waited, but no one answered. The child protection investigator learned later in the investigation that the shelter moved down the street to a new location earlier that month.

On August 13, 2021, the mandated reporter again contacted the Hotline and reported that the mother continued to breastfeed the baby, even though she was advised not to, as she was in a methadone program. The reporter added that while living at a homeless shelter the staff frequently had to remind the mother that her older child, the 8-year-old, was not responsible for caring for the baby. The report was taken as related information.

The child protection investigator documented that he was on vacation from August 13 to 19. On August 20, the child protection investigator went to the shelter's new location and interviewed staff who informed him that the family no longer resided at the shelter.

On August 31, 2021, the supervisor instructed the child protection investigator to contact the shelter where the mother had been living and confirm when the mother was at the facility, and to interview the mother. Twenty-four days later, the child protection investigator contacted the shelter and he confirmed that the mother no longer resided at the shelter, and he did not know where she was staying. Fifteen days later, the child protection investigator went to another shelter and spoke to staff who informed him that there was no one by the mother's name staying at the shelter.

On October 19, 2021, two months after the Hotline call, the then 9-month-old infant was pronounced deceased at the hospital after being found unresponsive following cardiac arrest on a train. The child protection investigator met with the 8-year-old brother at his grandmother's house later the same day, and he showed no signs of maltreatment and denied being fearful of his mother. The 8-year-old was taken into protective custody following the death of his sibling. On November 6, 2021, DCFS indicated the investigation for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect against the mother.

6. OIG Case 2021-2934

SCR #6C (01/19/2021-03/12/2021) Unfounded
Allegation #77-Inadequate Shelter to 3-week-old by grandmother
Allegation #82-Environmental Neglect to 3-week-old by grandmother
Ages of children in the home: 3 weeks, 11, 14, and 15 years old
Days until contact: 41

On January 19, 2021, an anonymous reporter called the Hotline and stated that a 15-year-old mother had a newborn baby and left the infant with her mother in an unsuitable home. The reporter stated that the home was abandoned, with broken windows and doors torn off. The reporter added that the home was filthy, infested with roaches and mice, had no running water, and space heaters were being used to keep the residence warm. The reporter alleged the teen mother was using drugs, and that there were many other adults living in the home. The investigation was opened for allegations #77-Inadequate Shelter and #82-Environmental Neglect.

That same day, the child protection investigator went to the address listed on the report, but no one answered the door. The child protection investigator observed the home to have windows and doors intact and left a letter in the mailbox. The child protection investigator also noted visiting another address but was told the family no longer lived there. On January 23, the child protection investigator made another attempt to the address, but no one answered the door.

Three weeks later, on February 13, 2021, an anonymous reporter called the Hotline to report that the infant's grandmother lived in an abandoned home with the teen mother and her child. The child protection investigator went to the reported address and noted that the house appeared empty, there were no broken

windows, and there was no light coming from the home. The child protection investigator also attempted to go to the home on February 16, but there was no response.

On February 19, the child protection investigator went to another address associated with the teen's maternal grandmother. The teen's grandmother confirmed that the teen mother and baby were living with her at this address but were not home at the time.

On February 28, the Hotline was notified that the infant's grandmother and maternal aunt had died in a house fire. Detectives denied that the teen mother and her infant were at the home when the fire occurred.

The child protection investigator met with family members at the maternal grandmother's home the next day and noted that the home was not safe or appropriate for an infant child. When the child protection investigator met with the mother, she reported that she had been living at this address with her grandmother, and that her aunt who lives in a neighboring state has guardianship of the infant. The child protection investigator contacted the neighboring state's child services, who arranged for the child protection investigator to FaceTime with the child. On March 12, 2021, the child protection investigator spoke to the neighboring state's investigator who had just completed a visit to the aunt's home; she reported it was appropriate and observed the infant.

On March 12, 2021, DCFS closed and unfounded the investigation for allegations #77- Inadequate Shelter and #82-Environmental Neglect.

7. OIG Case 2022-0471
SCR #7E (09/06/2020-12/05/2020) Unfounded
Allegation #11-Cuts Bruises Welts Abrasions and Oral Injuries by Abuse to 15-year-old by father and stepmother
Ages of children in the home: 2, 5, 12, 15, and 17 years old
Days until contact: 60

On September 6, 2020, a mandated reporter contacted the Hotline to report that a 15-year-old girl was taken to the hospital and was observed to have a black eye and appeared nervous when answering questions. In addition, her mother was not allowing her to answer questions when she was not in the room. Allegation #11-Cuts Bruises Welts Abrasions and Oral Injuries by Abuse by her mother and father was taken for investigation.

This same day, the on-call child protection investigator made a good faith attempt at the family's home, but no one answered the door. The child protection investigator left a business card on the door. There was no investigative contact documented until two months later.

On November 4, 2020, the child protection investigator made a good faith attempt to see the family at their home. The mother called the child protection investigator later that day and arranged a time for her to visit the home. On November 5, 2020, the child protection investigator met with the 15-year-old girl at her school. The 15-year-old reported that the injury occurred when she was riding in a golf cart while the family was camping. She reported that she fell out of the golf cart and was bleeding badly. The 15-year-old reported that when she got in trouble, her mother would yell at her, and her father would take her phone.

On November 6, 2020, the child protection investigator visited the family home and spoke to both parents and the rest of their four children, ages 2, 5, 12, and 17.

On December 5, 2020, DCFS closed and unfounded the investigation for allegation #11-Cuts, Bruises, Welts, Abrasions and Oral Injuries by Abuse due to insufficient evidence.

8. OIG Case 2022-0844
SCR #8A (11/04/2020-01/06/2021) Unfounded
SCR #23C (11/04/2020-01/04/2021) Unfounded
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to 16-year-old by adult sisters/guardian and to 6- and 4-year-old by mother
Allegation #76-Inadequate Food to 16-year-old by adult sisters/guardian, and 6- and 4-year-old by mother
Ages of children in the home: 4, 6, and 16 years old
Days until contact: 50

On November 4, 2020, an anonymous reporter contacted the Hotline to report concerns that a home did not have lights or heat and there were guns in the home that were, "laying out on the table while the kids were out running about." The reporter stated two sisters live together in the home. One of the sisters had two children, a 4-year-old boy and a 6-year-old boy. The other sister had no children of her own but was the primary caretaker for her younger brother, a 16-year-old, who is gang involved. Two companion investigations were opened for allegations #76-Inadequate Food, and #60-Environment Injurious to Health and Welfare by Neglect, one against the 4-year-old and 6-year-old's mother, and one against the teen's guardian/sister.

The investigator made a good faith attempt on November 4 to see the children, but when she arrived at the home, she was informed that no one with the family's last name resided at the address nor did any children live there.

On November 5, 2020, the supervisor instructed the child protection investigator to "return to the home to make contact with the family. Interview verbal child victims regarding the allegations. Inquire of minors if the home has working heat and electricity. Inquire of minors if they have observed any guns in the home."

The child protection investigator returned to the home on November 23, 2020 and was again told that the family did not reside at the address.

There were no additional attempts to see the family until December 24, 2020, when the investigator went to a different address. The mother of the 4-year-old and 6-year-old reported that she and her children do not live with her sister but were at the home visiting her sister. While at the home, the child protection investigator interviewed both sisters and the 4-year-old and 6-year-old children. The sisters denied that there were guns in the home and reported there is always food, and the home is heated. The sisters reported that the teen was incarcerated at the juvenile detention center for armed robbery. On December 30, the investigator interviewed the teen by phone. The teen reported that the 4-year-old and 6-year-old did not reside with him and his sister.

On January 4, 2021, DCFS closed investigation SCR#23C. On January 6, DCFS closed investigation SCR#8A. DCFS unfounded both investigations for allegations #60-Substantial Risk of Physical Injury/ Environment Injurious to Health and Welfare by Neglect and #76-Inadequate Food.

9. OIG Case 2022-0443
SCR #9A (01/29/2021-04/29/2021) Unfounded
Allegation #82-Environmental Neglect to 6-month-old and 2-year-old by mother
Ages of children in the home: 6 months old and 2 years old
Days until contact: 76

On January 29, 2021, an anonymous reporter contacted the Hotline to report that the family home was not suitable for children due to the presence of rotten food, dirty diapers, and pests. The reporter also stated the mother may try to move out of state after being informed that DCFS would be contacted. The investigation was opened for allegation #82-Environmental Neglect to the 6-month-old and 2-year-old by their mother.

On January 30, 2021, the child protection investigator attempted a visit at the residence. The child protection investigator knocked but there was no response. The child protection investigator then attempted to speak with the mother by phone but had to leave a voicemail.

On February 5, 2021, the supervisor instructed the child protection investigator to contact the family. Two days later, the child protection investigator made another unsuccessful attempt to see the children.

There were no other documented attempts to see the children until a subsequent oral report was received on March 16, 2021, by an anonymous reporter stating that the mother "is a neglectful parent who constantly leaves her children unattended. Her residence is filthy, unsafe, and unsanitary." The report was taken as related information. The child protection investigator then attempted to contact the reporter regarding these additional allegations but had to leave a voicemail.

On March 27, 2021, the child protection investigator went to the family's residence, but no one answered the door. The child protection investigator left his card on the security door of the residence. The temporarily assigned area administrator reviewed the case on March 30 and wrote in a case note that she found "no documentation of reasonable efforts" and extended the investigation, listing additional steps that needed to be taken.

On April 14, 2021, the child protection investigator attempted to speak with the reporter, sent two notices of investigation letters, attempted to call the alleged perpetrator at three different numbers with no success, and completed an Integrated Eligibility System (IES)[3] search and a diligent search. This same day, the child protection investigator contacted the maternal grandmother by phone. The maternal grandmother reported that the children were well cared for and that their home was "never nasty or dirty." The maternal grandmother stated that she would have her daughter contact the investigator.

That same day, the child protection investigator received a return call from the reporter. The reporter stated that he was the children's father and only made the report because the mother's family called the police on him. The father acknowledged that his children were not abused or neglected as he reported.

On April 15, 2021, the child protection investigator interviewed the mother and observed the 2-year-old and 10-month-old at their home. The child protection investigator did not observe the home to be as described in the Hotline report. On April 29, 2021, DCFS closed and unfounded the investigation for allegation #82-Environmental Neglect against the mother.

[3] The Integrated Eligibility System (IES) is a computer based public benefits application and management system for the State of Illinois.

10. OIG Case 2022-0603

SCR #10A (08/17/2021-10/06/2021) Unfounded
Allegation #82-Environmental Neglect to 3-year-old, 2-year-old, and 3-week-old by mother
Ages of children in the home: 3 weeks old, 2 and 3 years old
Days until contact: 42

On August 16, 2021, a DCFS field office received a voice message from an anonymous reporter stating that the address of a local family was unlivable and disgusting. The reporter stated that the doors were ripped off the hinges, and that there were three children living in the home. The field office staff called the information into the Hotline on the next day.

The Hotline worker determined that the children living at the reported address were a 3-year-old, a 2-year-old, and a then 3-week-old infant. The investigation was opened for allegation #82-Environmental Neglect.

On August 17, 2021, the child protection investigator visited the address, but the apartment building was locked. While at the residence, the child protection investigator tried calling the mother, but no one answered the phone. The same day, the supervisor spoke to the child protection investigator, who reported that she made a good faith attempt. The supervisor instructed the child protection investigator to send a letter to the mother.

The next documented attempted contact was over three weeks later, on September 9, when the child protection investigator visited the home, but again could not get into the apartment building. The child protection investigator tried calling but the phone number was disconnected. As the child protection investigator was walking away, someone was exiting the apartment complex and the child protection investigator went into the building. The child protection investigator observed two garbage bags and a broken headboard outside of the door of the apartment. The child protection investigator knocked several times on the apartment door, but there was no answer, and she left her business card.

On September 10, 2021, the child protection investigator contacted the mother via phone, and they made plans to meet the following Monday. Three days later, the child protection investigator went to the family's apartment and interviewed the mother. The mother reported that the children were at daycare. This same day, the supervisor instructed the child protection investigator to obtain the address for the daycare provider to see the children.

Two weeks later, the then 2-month-old was found unresponsive by his mother and an investigation for death by neglect was opened (SCR #10B). The following day, the child protection investigator assigned to the death investigation met with the family at their home and observed the surviving children, the 2-year-old and 3-year-old, to be safe.

On October 6, 2021, DCFS closed and unfounded the investigation against the mother for allegation #82-Environmental Neglect.

11. OIG Case 2020-0698[4]

SCR #11E (06/25/2019-09/20/2019) Indicated
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to 1-month-old, 6-year-old, 8-year-old, and 10-year-old by mother and mother's paramour
Ages of children in the home: 1 month, 6, 8, and 10 years old
Days until contact: 52

On June 25, 2019, a mandated reporter contacted the Hotline to report that a then 1-month-old infant, a 6-year-old, and a 10-year-old had witnessed intimate partner violence between their parents. The reporter also stated that the father's other child, an 8-year-old with whom he had court ordered visitation, was also present during the altercation. The 8-year-old's biological mother reported the violence to the reporter and requested assistance in obtaining an order of protection to protect the 8-year-old from her father. The investigation was taken for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect by both parents.

That day, the child protection investigator attempted to see the children at the father's home and made another attempt at the 8-year-old's mothers' home, but no one was at either home. The next day, the child protection investigator received a call from the 8-year-old's mother and arranged to see the 8-year-old at the mother's home.

The next day, on June 27, the child protection investigator made another attempt to see the other children at the father's home, but no one answered the door. That same day, a letter requesting that they contact the investigator was sent to the family.

On July 1, 2019, the child protection investigator interviewed the 8-year-old and her biological mother. The 8-year-old reported that she had witnessed her father and stepmother fight before. The 8-year-old reported that she had never been hit while at her father's home, but she does not like to go to his home. The 8-year-old's mother reported that she has an order of protection against 8-year-old's father.

On July 24, 2019, the child protection investigator interviewed the father at the DCFS field office. The father reported that his paramour (the mother of the infant, the 6-year-old, and the 10-year-old) was aggressive and would start fights, then call the police to get him in trouble. The father reported that he wanted the paramour to move out, but she refused. That month, the child protection investigator made three more good faith attempts on July 24, July 26, and July 31 to the family's home to see the other three children.

On August 21, 2019, almost two months after the Hotline call was made, the child protection investigator met with the mother of the infant, the 6-year-old, and the 10-year-old, and observed the infant at the home of the mother's sister. The 6-year-old and 10-year-old were not present. The mother refused to allow the child protection investigator into her sister's home, refused to sign a medical release, and declined intact services. The child protection investigator was unable to complete a home and safety check and could not confirm that the mother had a crib for the infant, nor could she verify the mother was living at her sister's house, as she was denied entry. After this contact, the child protection investigator marked the CERAP as safe because the child protection investigator did not observe the infant to have any marks or bruises, the mother was staying with her sister and no longer with her paramour, and the mother's sister said the infant was safe and she did not witness the June 2021 domestic violence incident.

The child protection investigator documented that she observed the 6-year-old and 10-year-old at their grandmother's house 52 days after the initial Hotline call. No additional details were documented.

[4] On February 25, 2020, the OIG issued a full investigative report on this case.

The child protection investigator again spoke to the mother of the infant, the 6-year-old, and the 10-year-old on August 26, 2019. The mother reported she was leaving her paramour and going to stay with her mother but refused to provide the child protection investigator with her mother's address. When the child protection investigator spoke with the mother a second time that day, she said she would like to participate in intact services, she wanted to keep her family together, and she wanted counseling for herself and her paramour. Later that day, the infant was found unresponsive, taken to the hospital, and pronounced deceased. DCFS opened an investigation for allegation #51-Death by Neglect against the parents.

On September 20, 2019, DCFS indicated the investigation for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect against both parents due to their history of domestic violence.

12. OIG Case 2022-0826

SCR #12F (10/19/2021-03/18/2022) Unfounded
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to 3-month-old, 2-year-old, and 7-year-old by mother
Allegation #82-Environmental Neglect to 3-month-old, 2-year-old, and 7-year-old by mother
Ages of children in the home: 3 months old, 2 and 7 years old
Days until contact: 50

On October 19, 2021, an anonymous reporter contacted the Hotline to report that the mother used drugs while in the presence of her children, a then 3-month-old infant, a 2-year-old, and a 7-year-old. Additionally, the reporter alleged that the mother had a sex offender in the home, had sex in front of the children, and the home was dirty. The investigation was opened for allegations #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect and #82-Environmental Neglect. An intact family services case for this family was pending at the time the investigation was opened.

The day after the Hotline call, the child protection investigator attempted to see the children, but no one answered the door.

On October 20, 2021, and again on October 28, the supervisor instructed the child protection investigator to interview the children and assess the home. The following day, the child protection investigator contacted the mother by phone, but no one answered. The child protection investigator was unable to leave a voicemail. One month later, on November 20, the child protection investigator attempted to see the children at the maternal grandmother's home but was unable to enter the apartment or speak to anyone on the phone.

On December 8, 2021, the child protection investigator contacted the intact family services caseworker, who stated that the father burned the mother's house down, and the children were living with their grandmother. When the child protection investigator spoke with the grandmother later that day, she confirmed that all the children were in her care and the mother would come to her apartment every day to help care for the children. The children were observed at the grandmother's home and were not found to be at risk of harm.

On December 21, 2021, it was reported to the Hotline that the infant passed away. It was reported that the mother and children fell asleep on the couch, and when the mother woke up, she found the 2-year-old asleep on top of the 5-month-old infant. An investigation was opened for death by neglect.

On March 18, 2022, DCFS closed and unfounded the investigation against the mother for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect and allegation #82-Environmental Neglect.

13. OIG Case 2022-1038

SCR #13A (11/16/2021-03/16/2022) Unfounded
Allegation #11- Cuts Bruises Welts Abrasions and Oral Injuries by Abuse to 12-year-old by father
Ages of children in the home: 12 years old
Days until contact: 63

On November 16, 2021, a mandated reporter contacted the Hotline to report that a 12-year-old's father was notified that his child had punched another child, and reporter later received an email from the 12-year-old child apologizing. The email also stated, "when I got home my dad hit me with a water hose on my leg and I still got a mark." The investigation was opened for allegation #11- Cuts, Bruises, Welts, Abrasions and Oral Injuries by Abuse.

The following day, the child protection investigator went to the address listed in the report and documented that no one was home. There were no other attempts documented until after a supervisory note dated January 15, 2022, instructed the child protection investigator to see the family.

On January 18, 2022, two months after the initial Hotline call, the child protection investigator interviewed the child at school. The child reported that the incident was not recent and occurred when both of his parents lived together. The child reported there were no problems at home, and he felt comfortable at home.

The child protection investigator interviewed the father the same day, and the father reported that he did not remember the incident. The child protection investigator completed a CERAP and determined the child to be safe.

There was no other contact documented until February 14, 2022, when the child protection investigator contacted the father by phone. The father reported that the child had passed away five days earlier after becoming ill at school and was taken to the hospital. The father reported that the child had an infection in his pancreas which led to cardiac arrest, and he was pronounced deceased. The death was ruled natural, and DCFS did not investigate the death for abuse or neglect.

On March 16, 2022, DCFS closed and unfounded the investigation against the father for allegation #11-Cuts Bruises Welts Abrasions and Oral Injuries by Abuse to the 12-year-old child.

14. OIG Case 2022-1006

SCR #14A (09/12/2021-01/31/2022) Unfounded
Allegation #10-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Abuse to 1-year-old by mother
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to 3-month-old and 1-year-old by mother, and to 3-month-old by father
Allegation #74a-Inadequate Supervision - Left Alone at Home, Outside or in the Community to 3-month-old and 1-year-old by mother
Ages of children in the home: 3 months old, and 1 year old
Days until contact: 123

On September 12, 2021, an anonymous reporter contacted the Hotline to report that the mother of a then 3-month-old infant and a 1-year-old would leave the children frequently to fight people and had "whooped" the 1-year-old. Additionally, it was reported that the father had guns "laying around" the residence and was gang affiliated. An investigation was opened for allegations #60-Substantial Risk of Physical Injury/ Environment Injurious to Health and Welfare by Neglect, #74a-Inadequate Supervision - Left Alone at Home, Outside or in the Community, and #10-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Abuse.

On September 13, 2021, the child protection investigator notified the supervisor that she had gone to the family's address, but no one answered the door. She then attempted to see the family at the address listed in the Integrated Eligibility System (IES), and the house was condemned. A family member sitting in his car nearby reported that there had been a house fire, and everyone was "living in different places," but he did not know where.

The child protection investigator documented a second attempt to see the family on October 4 and documented that she sent a letter to the mother that same day. No other attempts to locate the family were documented for another three months.

On November 10, 2021, the supervisor consulted with the child protection investigator, who reported that she had not been able to locate the family. The supervisor searched IES and found the mother and other children's dates of birth and an address.

On January 13, 2022, the child protection investigator returned to the home where she made her initial attempt to see the family four months earlier and met with the then 3-month-old infant and the 1-year-old. The children were assessed as safe, and the family denied the presence of guns and violence in the home.

On January 31, 2022, DCFS closed and unfounded the investigation against the parents for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect and unfounded the mother for allegation #10-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Abuse and allegation #74-Inadequate Supervision.

15. OIG Case 2022-1267

SCR #15B (03/23/2022-06/11/2022) Indicated
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to 7-year-old by mother
Ages of children in the home: 7 years old
Days until contact: 62

On March 23, 2022, the Hotline received a call alleging that a 7-year-old child witnessed his mother strike his father in the face numerous times. The reporter stated that the mother was high and had a history of phencyclidine (PCP) use. The reporter stated that the police were called to the scene, and they allowed the mother to leave with her daughter. The investigation was opened against the mother for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to the 7-year-old.

The next day, the child protection investigator went to the mother's home, rang the doorbell, and knocked on the door for several minutes without a response. The supervisor documented that the child protection investigator made a good faith attempt. This was the only documented attempt by the child protection investigator to see the child for almost two months.

On May 17, 2022, the supervisor documented that she completed a desk review of the investigation. The supervisor noted that the minor had not been assessed and instructed the child protection investigator to ensure the child and other subjects were assessed, ensure the alleged perpetrator was interviewed, provide the CANTS 8, and complete assessments.

On May 19, 2022, the investigation was reassigned to another child protection investigator. On May 24, the child protection investigator called the mother and scheduled a time to meet the mother and child at the home later that day. The child protection investigator completed the CERAP at the home visit and determined that the child was safe and documented that the child appeared happy and comfortable in the home with her mother.

On May 25, 2022, while the investigation was pending, the death of the 7-year-old was reported to the Hotline. DCFS opened a separate investigation against the mother for death by abuse; the mother later admitted to suffocating her daughter.

On June 11, 2022, DCFS indicated the investigation against the mother for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect.

16. OIG Case 2022-1293

SCR #16A (02/16/2022-03/21/2022) Unfounded
Allegation #78-Inadequate Clothing to 10-year-old by mother
Ages of children in the home: 1 month old, 5, 10, and 12 years old
Days until contact: 27

On February 16, 2022, a mandated reporter contacted the Hotline alleging that a 10-year-old child wore the same stained clothes every day. The reporter also stated that the child had not attended school since January. An investigation against the mother for allegation #78-Inadequate Clothing was opened.

Following the Hotline call, the child protection investigator attempted to see the family at the address listed in the report. When the child protection investigator went to the listed address, the owner of the

building reported that he had owned the building for a year, and the family had not lived at the address during that time.

On February 25, 2022, the child protection investigator conducted an Integrated Eligibility System (IES) search and obtained another address associated with the family. She went to the address but received no response to the doorbell or knock.

On February 28, 2022, the child protection investigator attempted to call the mother, but she did not answer the phone.

On March 9, 2022, the child protection investigator sent a letter to the family's home. On March 14, the child protection investigator received a call from the mother, who reported that she received the letter and she agreed to meet the next day.

On March 15, 2022, the child protection investigator met the mother and the four children at their home, 27 days after the initial report. The 10-year-old stated that he took a bath every night and had plenty of clothes but preferred to wear his old clothes. The child protection investigator observed the other children in the home. The mother denied the allegations and stated that the 10-year-old just liked to wear his favorite clothes all the time.

On March 21, 2022, DCFS closed and unfounded the investigation for allegation #78-Inadequate Clothing against the mother.

17. OIG Case 2021-1853

SCR #17B (01/05/2020-03/06/2020) Unfounded
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to 8-month-old by mother
Ages of children in the home: 8 months old
Days until contact: 44

On January 5, 2020, the Hotline received a report alleging that the mother of an 8-month-old infant had been giving the infant melatonin for sleep and the medication had not been prescribed by a doctor. It was also reported that the mother was intoxicated and using drugs while caring for the infant. The investigation was opened for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to the infant by the mother.

Following the Hotline call, an after-hours child protection investigator made a good faith attempt to see the mother and infant but was unable to gain access to the building, a multi-unit complex.

On January 26, 2020, the supervisor entered a supervisory note documenting that only one attempt had been made to see the alleged child victim. The supervisor instructed the child protection investigator to check public aid and prior reports for addresses and phone numbers and to make daily attempts to see the alleged victim.

On February 7, the child protection investigator attempted to see the family at their home but documented he could not gain access to the building.

On February 17, 2020, while the B-sequence investigation was pending, the Hotline received another call alleging that the mother's ongoing anger issues placed the infant at risk. The reporter stated that two weeks earlier, the mother had "trashed" her apartment, breaking multiple items; and had consumed alcohol to the

point of intoxication, which impacted her ability to care for the infant. The C-sequence investigation was assigned to the child protection investigator, who had not yet seen the infant since his assignment to the B-sequence investigation.

On February 18, 2020, the child protection investigator made his first contact with the child and alleged perpetrator, 44 days after the initial Hotline call. The child protection investigator documented that he met with the mother and child victim at their home.

On March 6, 2020, DCFS closed and unfounded the B-sequence investigation for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect.

18. OIG Case 2022-0193

SCR #18E (06/06/2021-12/03/2021) Unfounded
Allegations #11-Cuts Bruises Welts Abrasions and Oral Injuries by Abuse to 8-year-old by mother
Ages of children in the home: 1, 4, 5, 6 and 8 years old
Days until contact: 123

On June 6, 2021, the Hotline received a call alleging that while in the care of her mother, an 8-year-old child sustained bruises to her inner thigh and arm. The reporter stated that the mother told the reporter that the inner thigh bruising was poison ivy, but the reporter stated that it looked like the 8-year-old had been raped. The reporter stated that he did not see the bruises in person, and the 8-year-old did not make an outcry of sexual abuse. The investigation was opened with allegation #11-Cuts Bruises Welts Abrasions and Oral Injuries by Abuse against the 8-year-old's mother.

That day, an on-call child protection investigator went to the home to meet with the family, but no one answered the door. The next day, the primary child protection investigator attempted to see the family at the home but again, no one answered the door.

On June 10, 2021, the 8-year-old's father made two additional Hotline calls requesting information on the status of the investigation. Later that day, the child protection investigator made another attempt to see the family at their home, but no one answered the door.

On June 22, 2021, the child protection investigator spoke to the mother by phone and arranged to meet with the family, but when the child protection investigator arrived at the home, no one answered the door. The child protection investigator called the mother back, and the mother said to come back the following day.

On July 16, 2021, the Hotline received a report that the day before, the mother had given birth at 35 weeks gestation, and the newborn had a hernia and a hole in his diaphragm. The baby passed away later that day due to respiratory failure.

There were no documented attempts to see the family between June 22 and August 9, 2021. On August 10, another child protection investigator documented that she attempted in-person contact with the family but there was "no answer to attempt."

The next documented investigative contact was on October 6, 2021, when a third child protection investigator met with another child listed on the report and her father at a different residence.

On October 7, four months after the initial Hotline call, the third child protection investigator met with the 8-year-old and her mother at a local park. The 8-year-old denied having bruises in June and denied that

anyone hit her. The next day, the child protection investigator went to the mother's home and met with the remaining children on the report, a 6-year-old, a 5-year-old, and a 4-year-old.

On December 3, 2021, DCFS closed and unfounded the investigation against the mother for allegation #11-Cuts Bruises Welts Abrasions and Oral Injuries by Abuse to the 8-year-old.

19. OIG Case 2021-0069[5]
SCR #19A (11/29/2019-01/28/2020) Unfounded
Allegation #82-Environmental Neglect to 8-month-old and 3-year-old by mother
Ages of children in the home: 8 months old and 3 years old
Days until contact: 53

On November 29, 2019, an anonymous reporter contacted the Hotline and reported the mother was not providing appropriate care towards her children, a 3-year-old and an 8-month-old, and that their home had a cockroach infestation. Additionally, the reporter alleged that the mother co-slept with the infant. The reporter refused to provide addresses for the locations of the children. The report was taken for investigation of allegation #82-Environmental Neglect.

That afternoon, an on-call child protection investigator went to the home to see the mother and children. The child protection investigator spoke to the mother, who reported that her children did live there, but they were not home. The child protection investigator was denied entry because the homeowner/grandmother was not at the residence at the time of contact. The grandmother reported that she would make herself available the following Monday, and the child protection investigator explained that the primary investigator would make contact that day.

On December 2, the child protection investigator attempted to contact the anonymous reporter by phone, but no one answered, and she left a message. Later that day, the child protection investigator went to the family home, but no one answered the door. The child protection investigator documented two additional good faith attempts to see the family on December 3, and December 5.

There was no documented investigative activity from December 5, 2019, until January 10, 2020, when the child protection investigator again attempted to contact the reporter by phone, received no answer, and left a second message. The child protection investigator's first and only visit with the family occurred on January 21, 2020, almost two months after the Hotline call. The child protection investigator documented seeing both the toddler and the infant and assessed them as safe. On January 28, 2020, DCFS closed and unfounded the investigation for allegation #82-Environmental Neglect.

[5] On May 7, 2021, the OIG issued a full investigative report on this case.

20. OIG Case 2022-0913[6]

SCR #20A (07/02/2021-05/03/2022) Unfounded
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to 4-year-old and 10-year-old by mother
Allegation #74c-Inadequate Supervision - Left in the Care of an Inadequate Caregiver to 10-year-old and 4-year-old by mother
Ages of children in the home: 4, 10, 13 and 14 years old
Days until contact: 223 (10-year-old) and 303 (4-year-old)

On July 2, 2021, the Hotline received a call that a mother of four children, ages 4, 10, 13 and 14, had used crack cocaine, and the 10-year-old had not been attending school and had been "running the streets." The reporter stated that 10-year-old was often left home to babysit her 4-year-old sister. It was also alleged that the mother had suicidal thoughts and cut herself three days prior. The report was taken for investigation for allegations #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect and #74c-Inadequate Supervision - Left in the Care of an Inadequate Caregiver to the 4-year-old and 10-year-old.

That same day, the child protection investigator attempted to visit the family at their apartment, but the outside doors were locked, and the investigator was unable to gain access to the building.

There was no additional investigative activity for three months. On September 11, 2021, a second child protection investigator went to the residence, but was not able to gain access to the building. This same day, the second child protection investigator spoke to the children's grandmother by phone, who stated that the 10-year-old child was with her that day.

On October 16, 2021, a third child protection investigator attempted to see the children but was unable to gain access to the building and noted that the building had no bells or buzzers.

On November 27, 2021, a fourth child protection investigator went to the home to assess the children, but no one answered the door. While the child protection investigator was at the home, the police arrived at the apartment complex after a 911 hang-up and were told which apartment the mother lived in, but no one answered the door.

On January 24, 2022, the OIG received a general complaint regarding this family. An OIG investigator conducted a public aid and Medicaid search for the family. The OIG investigator did a SACWIS/CYCIS search and learned that the mother was an alleged perpetrator on seven other child protection investigations, and had two other children in her care, a 13-year-old and 14-year-old. On February 7, the OIG investigator called the supervisor, and provided information to the supervisor regarding the other children. The supervisor told the OIG investigator that the investigators had high caseloads and had not had a chance to make contact.

On February 7, 2022, the first child protection investigator documented another failed attempt to see the children at two different addresses.

On February 9, 2022, the first child protection investigator went to the home and met with 10-year-old privately at her residence. The child protection investigator documented no concerns.

The first child protection investigator made two additional good faith attempts to see the 4-year-old between April 7 and April 12, 2022. On April 30, the child protection investigator documented she "observed the

[6] This investigation came to the attention of the OIG through a general complaint, not a child death.

minor with no signs of abuse or neglect. Minor did not speak with child protection investigator and is too young to interview."

On May 3, 2022, DCFS closed and unfounded the investigation for allegations #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect and #74c-Inadequate Supervision – Left in the Care of an Inadequate Caregiver

21. OIG Case 2022-0622

SCR #21A (08/22/2020-10/21/2020) Unfounded
Allegation #10-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Abuse to 16-year-old by adoptive mother's adult children
Allegation #11-Cuts Bruises Welts Abrasions and Oral Injuries by Abuse to 16-year-old by adoptive mother's adult children
Allegation #74c-Inadequate Supervision – Left in the Care of an Inadequate Caregiver to 16-year-old by adoptive mother
Ages of children in the home: 5 and 16 years old
Days until contact: 36

On August 22, 2020, the Hotline received a call that a 16-year-old, adopted child got in a verbal argument with her adoptive mother's adult children. The reporter stated that the 16-year-old reported that the 25-year-old twin brothers had hit, choked, pushed her down the stairs, and told her to leave the home. The reporter called the local police who went to the home and arrested the brothers, who were not supposed to be living in the home due to past incidents.

An investigation was opened for allegations of #10-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Abuse and #11-Cuts, Bruises, Welts, Abrasions and Oral Injuries by Abuse to the 16-year-old child by her adoptive mother's sons, and allegation #74c-Inadequate Supervision – Left in the Care of an Inadequate Caregiver to the teen by her adoptive mother were taken for investigation.

The following day, August 23, 2020, the child protection investigator made a good faith attempt to see the 16-year-old child at the reported address and was informed by a person who refused to identify himself that the teen and her adoptive mother were at church. The child protection investigator spoke to the person, who stated that he was involved with the incident involving the teen, and had been arrested, along with his twin brother.

On September 27, 2020, the supervisor met with the 16-year-old and interviewed her regarding the incident, 36 days after the initial report. The supervisor did not observe any marks or bruises on the teen. The supervisor also met with and interviewed one of the twin brothers. The next day, the supervisor observed the adoptive mother's 5-year-old son in the home. On October 20, the supervisor spoke on the phone with the adoptive mother's son and the other twin brother.

The following day, October 21, 2020, DCFS closed and unfounded the investigation for allegations #10-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Abuse, #11-Cuts Bruises Welts Abrasions and Oral Injuries by Abuse, and #74c-Inadequate Supervision.

22. OIG Case 2021-3154 (SCR #22A)[7]

SCR #22A (11/07/2018-04/04/2019) Indicated against father, Unfounded against mother
Allegation #10-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Abuse to 1-year-old and 2-year-old by mother and father
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to 1-year-old and 2-year-old by mother and father
Ages of children in the home: 1 and 2 years old
Days until contact: 131

On November 7, 2018, a mandated reporter contacted the Hotline to report that the mother's sister reported that the mother and father of a 1-year-old and 2-year-old physically fought in front of their children. In addition, the sister told the reporter that the father also hit his two children, the 1-year-old and 2-year-old. The investigation was opened for allegations #10-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Abuse and #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect.

The next day, the child protection investigator documented that she made a good faith attempt. No other information, such as observations of the home were noted. This was the only documented attempt that the child protection investigator made to observe the children.

No other investigatory tasks were completed until the investigation was reassigned to another child protection investigator on March 15, 2019. The same day, the child protection investigator called and left a message for the reporter. A supervisory contact note from the same day reads: "CPS will complete this investigation following procedures 300. The child victims have not been seen."

The following day, the child protection investigator received a call from the reporter, who reported that the mother no longer lived in Illinois and had recently relocated out of state.

The child protection investigator attempted to call the mother twice on March 17, 2019, and made contact on March 18. The child protection investigator documented that she spoke to the mother who expressed that her children were safe. The child protection investigator spoke with a municipal police officer in the mother's new location on March 18, who confirmed that the 1-year-old and 2-year-old children were safe in their home environment.

On April 4, 2019, DCFS closed and indicated the investigation against the father for allegations #10-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Abuse and #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect against both children. DCFS unfounded the investigation against the mother for both allegations.

23. OIG Case 2021-3154 (SCR #22B)[8]

SCR#22B (01/02/2020-03/02/2020) Unfounded
Allegation #82-Environmental Neglect to 5-month-old, 2-year-old and 3-year-old by mother
Ages of children in the home: 5 months, 2 and 3 years old
Days until contact: 59

On January 3, 2020, an anonymous reporter called the Hotline stating that the mother and her sisters were living in a residence with significant mold issues with her three young children. The reporter also stated

[7] On June 27, 2022, the OIG issued a full investigative report on this case.
[8] On June 27, 2022, the OIG issued a full investigative report on this case.

that there was another adult in the home with serious mental health issues. The investigation was opened with allegation #82-Environmental Neglect.

The day the report came in, the child protection investigator went to the home to attempt a home visit, but no one answered the door, so the child protection investigator left her business card.

On January 6, 2020, the child protection investigator met with one of the sisters in the home. She reported the home was in foreclosure after the death of their mother. She reported there was mold in the basement, but the children do not go in the basement. The sister reported that she had one child, who lived in the home, and her youngest sister lived in the home. The sister denied that the three alleged child victims and their mother lived in the home.

On January 15, 2020, the child protection investigator spoke with the youngest sister on the phone who denied having mental health issues and reported that she helped her sister with her son. She confirmed that the child did not have access to the basement.

On February 25, 2020, the child protection investigator went to an address found on the family's public aid information and rang the doorbell, but no one answered the door. She sent a certified letter to the same address.

On February 26, 2020, the child protection investigator received several phone calls from the mother. When she attempted to return the call, the mother did not answer, and the child protection investigator left a voice message. Two days later, on February 28, the child protection investigator received a return phone call from the mother, who reported she was currently living with a friend, and added she would call the child protection investigator back to inform her when she could come out to the home.

On March 2, 2020, two months after the initiation of the investigation, the child protection investigator observed all three alleged child victims and met with their mother. The mother reported she had been living at that residence for six months.

On March 2, 2020, DCFS closed and unfounded the investigation for allegation #82-Environmental Neglect against the mother.

24. OIG Case 2021-3154 (SCR #22C)[9]

SCR #22C (08/27/2020-12/24/2020) Indicated
Allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to 1-year-old, 2-year-old, 4-year-old, and 6-year-old by mother
Allegation #82- Environmental Neglect to newborn, 1-year-old, 2-year-old, 4-year-old, and 6-year-old by mother
Ages of children in the home: 1, 2, 4 and 6 years old and newborn (born three days after report)
Days until contact: 64

On August 27, 2020, an anonymous reporter contacted the Hotline to report that the mother and aunt were known to use pills, marijuana, and alcohol in front of the four children, and that they lived in an unsuitable environment. The investigation was opened for allegations #60-Substantial Risk of Physical Injury/ Environment Injurious to Health and Welfare by Neglect and #82-Environmental Neglect.

[9] On June 27, 2022, the OIG issued a full investigative report on this case.

Following the Hotline call, the child protection investigator made a good faith attempt to see the family, but no one answered the door. On August 30, 2020, the supervisor instructed the child protection investigator to complete well-being checks, complete a home safety checklist, and other tasks.

On September 3, 2020, the child protection investigator documented that she again attempted to see the family, but no one answered the door.

On September 23, 2020, the supervisor entered a supervisory note stating that the children had not been seen, and the child protection investigator needed to complete diligent search efforts to locate and assess the family. That same day, the child protection investigator documented that she mailed a letter to the home requesting in person contact.

On October 18, 2020, a different supervisor documented that she contacted the child protection investigator and instructed her to meet with the family, assess the home, have the mother take a toxicology screening, and complete a nursing referral.

On October 21, 2020, the child protection investigator made a third attempt to meet with the family and again noted that there was no answer.

On October 29, 2020, the child protection investigator attempted to see the family at the home of the children's paternal grandmother. The grandmother told the child protection investigator that she did not have the mother's number, but she would call her son to see if he had a number. The child protection investigator left her name and number.

On October 30, 2020, two months after the initial report, the child protection investigator went to the home and made contact with the family. At the home were the mother and her three children, the 4-year-old, the 3-year-old, the 1-year-old, and a newborn, who was not listed on the investigation as he was not born until after the allegations were reported to the Hotline. The children's aunt was also at the home. The child protection investigator documented that no marks or bruises were seen on the children, and no concerns were observed.

On November 27, 2020, the child protection investigator documented that she interviewed the 6-year-old, the aunt's son, who was also listed on the report. The child protection investigator documented that the 6-year-old was dressed appropriately and noted no concerns.

On December 24, 2020, DCFS closed and indicated the investigation against the mother for allegation #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect due to her history of domestic violence and testing positive for marijuana. DCFS unfounded the investigation against the mother for allegation #82-Environmental Neglect.

ANALYSIS

During the OIG's review of complaints and child deaths from FY 20 through FY 22, the OIG identified a systemic pattern in child protection investigations where there was a significant delay in child protection investigators making initial contact with the child(ren) after a Hotline call. In this sample of child protection investigations, OIG investigators found that child protection investigators and their supervisors failed to assess the safety of the alleged child victims in a timely manner. The OIG review found that 11 of the 24 child protection investigations reviewed involved children under 1 year old; 20 of the 24 child protection investigations involved children 3 years and under; and 22 of the 24 child protection investigations involved children 5 years and under. The review also found that this occurrence was statewide and included both abuse and neglect allegations. The time frames ranged from just under a month to over 100 days before

contact was made with the child(ren). In several of the investigations, it was not until the investigation came due, a subsequent Hotline call was made, or a child died, that further attempts were made to see the family.

Staff shortages, high caseloads and the COVID-19 pandemic have no doubt made the job of child protection more difficult, yet the basic function of promptly seeing the alleged victims of abuse or neglect remains. For the Department to fulfill its mission to protect children who are reported to be abused or neglected, more must be done to ensure a timely assessment of child safety. Too often, investigations linger for months and when a child is finally seen, the assessment is superficial. The urgency has passed for both the investigator and the family. It can become a task to complete and check off, rather than an assessment of the child's safety and the parent's ability to care for their child. An investigation open for a long period of time with no activity serves neither the families nor the Department. The Department has an obligation to the public and the families they serve to investigate reports of abuse and neglect in a timely manner.

Barriers such as a family moving and families not being at home can prevent contact. However, only a few child protection investigators documented completing a diligent search or using the IES system to locate the family. In addition, using schools and daycares as a resource to locate the family were often not utilized until later into investigations, if at all. Police were also not called to request well-child checks in the event the investigator was unable to make contact with the family. All shift alerts (Cook) or on-call workers (non-Cook Counties) were rarely utilized. The Department has resources such as all shift alerts and on-call workers; Department administration must determine under what circumstances these should be used when DCP is having difficulty locating the family.

Supervisors routinely instructed investigators to continue making attempts. A reminder to make another attempt should be accompanied by a plan and evaluation of why previous attempts were not successful. Part of the plan should include using information found in previous investigations (i.e., names and contact information of relatives, schools, daycares, and doctors) or calling police who may have had contact with the family. Certainly, there exists no one remedy. Area and Regional Administrators may need to assist investigative teams when a child has not been seen. On a macro level, administrators should be forming contacts with other agencies, such as local law enforcement, school districts and community providers so they can assist in locating families.

Procedurally, the importance of seeing children is evident through the extensive guidelines set forth in Procedures 300. Procedures 300.50(c), *Initiation of the Investigation*, requires that "the safety of all alleged child victims must be assessed before an investigation is considered initiated" and that the child protection specialist shall take whatever steps are necessary to obtain the current location of the alleged child victims and proceed immediately to their location. Good faith attempts must be made every 24 hours or sooner, including weekends and holidays, until the alleged child victim is seen, unless a waiver is granted by the Child Protection Supervisor. Procedures notes that, "the fact that a good faith attempt was made and that the 24-hour mandate was technically met does not relieve the Child Protection Specialist of the responsibility for continuing to attempt to establish in-person contact with the alleged child victim as soon as possible."

The OIG recognizes that child protection investigations reviewed by the OIG are only a small sample of the total number of child protection investigations completed and may not be representative of all child protection investigations However, this sample covers all regions, indicating it could be a statewide issue. The Department should review the current status of this issue. In addition, Department Administration must develop a plan to ensure that more efficient efforts are made to meet with alleged child victims at the inception of the investigation.

RECOMMENDATIONS

1. The Department should review the current status of children that have not been seen in child protection investigations within a week of the Hotline call and develop a plan to ensure that the safety of the children has been immediately assessed.

2. Department Administration must develop a plan to ensure that more efficient efforts are made to meet with alleged child victims at the inception of the investigation.

3. The OIG reiterates the previous recommendation from 2021 IG 0069. The Department should increase the number of Emergency Services workers available for after-hours and on weekends to ensure that children are being seen in a timely manner.

4. The OIG reiterates the previous recommendation from 2013 IG 1109, that if child protection investigators cannot meet their obligation to assess child(ren) in a timely manner the supervisor should assure that the police are contacted for a welfare check.

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: **2022 IG 0623**
Child: **Camille Ball (DOB 05/2021; DOD 09/2021)**
Subject: **Child Death**

SUMMARY OF COMPLAINT

Four-month-old Camille Ball was discovered by her mother, Maria Ball, unresponsive and wedged in between an adult sized mattress and the wall. Camille had been placed in the adult sized bed by her mother the night before and Ms. Ball denied hearing Camille during the night. Ms. Ball called 911 and a neighbor attempted CPR prior to first responders arriving. Camille was taken to the hospital, where she was pronounced deceased. Ms. Ball has an extensive history of child neglect in another state, including an open placement case involving her two older children due to ongoing concerns for Ms. Ball's mental health and substance abuse. Maria Ball fled to Illinois to give birth to Camille presumably to avoid Child Protective Services from taking custody.

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 and a pending child protection investigation at the time of Camille's death, as well as two unfounded child protection investigations within the year.

INVESTIGATION

Background

Camille Ball was born in May 2021, to Maria Ball (DOB 07/1996) and Nate Levin (DOB 03/1995). Ms. Ball has two older children, Jasiah Knowles (DOB 11/2015) and Henrik Knowles (DOB 05/2019), who were removed from her custody in 2019 by another state's child protective services agency and remained in their placements in that state. Ms. Ball had an extensive history with the other state's child protective services agency dating back to 2016 due to ongoing concerns regarding her mental health, substance use, medical neglect, and inadequate supervision. Ms. Ball had an open case in the other state to receive supportive services in order for the family to remain intact but signed an affidavit which stated that she was "temporarily unable to provide for her children." The case was taken to juvenile court and in September 2019, Jasiah and Henrik were placed into foster care. Ms. Ball was not compliant with services and continued to use drugs.

SCR #2222222A June 3, 2021 – July 2, 2021
Allegation #60- Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to Camille Ball by Maria Ball- Unfounded

On June 3, 2021, a worker with child protective services from the other state called the Illinois Child Abuse and Neglect Hotline to report the following:

> Ms. Ball has an open case with CPS in another state where her two older children have been placed in foster care. Ms. Ball tested positive for cocaine on a hair follicle test in July 2020 and was positive for marijuana in January 2021. Ms. Ball has been non-cooperative with her services, and she was informed that this baby would need to be seen and assessed by someone from CPS. Ms. Ball has fled to Illinois and has refused to give CPS in the other state any access to the baby. There are serious concerns for her mental health and drug use and how it pertains to the safety and risk to the baby.

The Department opened an investigation for substantial risk to Camille by her mother, Ms. Ball. The investigation was assigned to Child Protection Investigator (CPI) Coral Majors,[1] supervised by Public Service Administrator (PSA) Yolanda Barnes.[2] CPI Majors spoke with the reporter who stated that Ms. Ball has a pending child protection investigation in another state, and the reporter was the assigned investigator. The other state's child protective services worker explained that Ms. Ball had a history of substance abuse and mental health concerns; she had not been compliant with the placement worker or services, and the case was moving towards termination of Ms. Ball's parental rights. Ms. Ball reportedly did not know who Camille's father was. Ms. Ball had reportedly been homeless, and it was believed she was staying in a domestic violence shelter in Illinois. CPI Majors then spoke with the placement case worker from the other state, caseworker Ruby Moss. Caseworker Moss reported that Ms. Ball's case came to the attention of the state's family services agency due to medical neglect of Ms. Ball's son, and they discovered that Ms. Ball had a history of unaddressed mental health and substance use issues. Caseworker Moss reported that Ms. Ball had requested that the children be taken into custody due to Ms. Ball being unable to care for the children.[3] Ms. Ball had not been compliant with toxicology screenings or in person visitation with the children. Ms. Ball completed a psychological evaluation and was diagnosed with bipolar disorder, hypomania, and chemical misuse. Ms. Ball had been recommended to follow through with mental health treatment and medication although failed to do so. Ms. Ball had not completed recommended substance abuse evaluation or parenting services and had failed to maintain adequate housing and employment. Caseworker Moss reported that Camille would have been taken into custody if Ms. Ball had delivered in the other state and noted that Ms. Ball had stated that "they will have to kill her (Ms. Ball) first to get the baby (Camille)." Ms. Ball was on probation, which Caseworker Moss believed was another reason that Ms. Ball fled, as she did not want to deliver the baby while in jail. Caseworker Moss believed Ms. Ball may be staying with her father, Samson Ball, and provided Mr. Ball's address in Pavlov, IL.

On June 4, CPI Majors went to the home of Ms. Ball's father, Samson Ball. Mr. Ball reported that Ms. Ball and Camille were at a shelter. Mr. Ball reported that he was willing to help Ms. Ball as much as possible to get her back on her feet and that Ms. Ball came from the other state in April.

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[1] CPI Majors started with the Department in January 2019, and previously worked as a placement and Intact CWS with a private agency for three years.
[2] PSA Barnes has been working in child welfare for 22 years and started with the Department in 2008.
[3] Child welfare documents from the other state indicated that Maria had signed an affidavit which stated that she was "temporarily unable to provide for her children." The case was taken to court and the children were placed in care in September 2019. CPI Majors told OIG investigators that she requested the other state's child welfare documents, but they were not received prior to the investigation closing. CPI O'Neal requested the records again while the B- and C-sequence investigations were pending, but they were not received until September 2021. The other state's records were in the DCP investigation attachments and OIG investigators reviewed the other state's child welfare records.

CPI Majors then traveled to Delta Refuge to meet with Ms. Ball and Camille. CPI Majors reported that she spoke briefly to Delta Refuge staff who reported that Ms. Ball had been at the shelter for about two weeks and had been cooperating with the program thus far. CPI Majors then spoke to Ms. Ball, who reported that she was working with Delta Refuge's program to obtain transitional and stable housing. Ms. Ball reported to CPI Majors that she came to Illinois as there were no resources to help her in the other state. Ms. Ball reported that her older two children were in foster care, and she had been unable to complete recommended services due to lack of transportation. CPI Majors told OIG investigators that the other state's placement worker did not report that transportation was a barrier to Ms. Ball engaging in services. Ms. Ball told CPI Majors that the only service required for the children to be returned to her care was for her to obtain appropriate housing. Ms. Ball reported that she completed a psychological evaluation but denied that she was diagnosed with any mental health conditions. She reported that she did not know that mental health treatment and medication had been recommended. Ms. Ball denied use of cocaine and reported that the only way she could have tested positive for cocaine was if the marijuana she smoked was laced unbeknownst to her. Ms. Ball reported previous domestic violence with her older children's father and reported that she did not know who Camille's father was but believed that people called him "Nate." Ms. Ball reported that she was on probation in another state for assault against a family member, but her probation officer did not know she was in Illinois. CPI Majors directed Ms. Ball to notify her probation officer of her move to Illinois. CPI Majors reported to OIG investigators that she did not request contact information for Ms. Ball's probation officer and CPI Majors did not speak with the probation officer during the investigation. CPI Majors did not speak to Ms. Ball about the possible consequences of Ms. Ball leaving the state while on probation and CPI Majors did not request an out of state LEADS. CPI Majors explained Intact Family Services and Ms. Ball agreed to services. CPI Majors gave full disclosure that should Ms. Ball not cooperate with services, her baby may come into care.

While at the shelter, CPI Majors observed Camille and noted no visible signs of abuse or neglect. Camille was assessed safe. That day, CPI Majors completed a CERAP and determined Camille was safe. The safety decision stated,

> CPI met with mother and child at Delta Refuge in Pavlov. Mother moved in Pavlov approximately one month ago and has been at the shelter for approximately 2 weeks. Mother moved to Pavlov to get back on her feet and has support in Pavlov. Mother does have an open placement case in another state but failed to get the support from her placement worker to get back on her feet. Mother has a service plan at Delta Refuge and is working on getting into the transitional living program, Epsilon CPI offered an intact family service case and mother accepted. No safety concerns at this time. CERAP is safe.

CPI Majors reported to OIG investigators that protective custody was ruled out because Ms. Ball was participating in services at Delta Refuge, had a service plan, Camille was not born substance exposed, and Ms. Ball agreed to Intact Family Services. PSA Barnes reported to OIG investigators that protective custody or implementation of a safety plan was ruled out because "mom had gotten herself signed up for WIC, she was getting assistance, she had gotten herself into Delta Refuge, baby appeared healthy, people at Delta Refuge said mom appeared to be doing great with the baby, she agreed to Intact services, she was cooperating, she said that she wanted assistance. We really didn't see anything at that point to suggest the baby was unsafe." PSA Barnes went on to report the decision to open an Intact case was "made very quickly" as the public service administrator and child protection investigator did not feel there was "immediate and urgent" need to take protective custody, but that Ms. Ball needed services and needed to be linked up with services in Illinois. PSA Barnes reported to OIG investigators that if they took protective custody at that time, the case would not "get through court," but acknowledged that more information should have been obtained prior to closing the investigation.

On June 8, CPI Majors sent a request to Pavlov Police Department for all records on Ms. Ball and was informed that no records existed. A handoff was completed with DCFS for Intact Family Services on June 11, and the transitional visit took place on June 15. CPI Majors confirmed with Camille's pediatrician that she was up to date with well child exams.

On June 25, PSA Barnes entered a final supervisory note stating:

> The allegation was made that Maria Ball neglected her infant daughter due to a history of drug abuse and domestic violence in the other state. CPS staff in another state have an open placement case due to Maria's older children being in foster care. They planned to take protective custody of this baby when they learned that Maria fled from the other state to be with her family in Illinois. Maria had the baby two weeks prior to the receipt of this report and was living in a shelter. CPI met with her, and Maria reported that she left the other state because she needed to get away from people who were bad influences and needed to be closer to family who could be supportive. She is getting counseling at the shelter and was willing to have an Intact Case in Pavlov to address ongoing issues. Baby Camille and Maria did not test positive for any substances at the time of birth. CPI spoke with professionals and relatives with knowledge of Maria. CPI did not gather information to support that Maria had created a risk of harm to her newborn at this time. Despite her history with prior children, this child was assessed as safe, and an Intact Case was opened to provide oversight and support. CPI recommends that the allegation #60 be unfounded. PSA agreed with CPI's recommended finding.

The investigation was unfounded and closed on July 2, 2021. PSA Barnes reported to OIG investigators that if Ms. Ball's placement case had been in Illinois, the decision to unfound the allegation would likely have been different as the child protection investigator and public service administrator would have had immediate and direct access to Ms. Ball's history with the Department.

Intact Family Services Case June 15, 2021 – March 15, 2022[4]

The case was assigned to child welfare specialist (CWS) Marcus Holmes[5], supervised by PSA Leslie Booker[6] with DCFS for Intact Family Services. CWS Holmes reported that the DCP investigator did not provide them with the child welfare records from the other state, and that Ms. Ball did not provide details as to why her older children were in care. CWS Holmes reported that he spoke briefly with the placement worker in the other state at case opening but was not provided with substantial information related to Ms. Ball's placement case in that state other than Ms. Ball had a history of substance abuse and mental health issues. Ms. Ball was tasked with completing a substance abuse assessment, random toxicology screenings, a mental health assessment, domestic violence classes, and to maintain adequate housing and employment.[7] On July 1, CWS Holmes documented that Ms. Ball was engaged in domestic violence services through Delta Refuge where she and Camille were residing and that Ms. Ball had expressed a desire for CWS Holmes to assist in getting Ms. Ball a counselor as Ms. Ball "would like to get back on her meds." Ms. Ball

[4] Camille died in September 2021, and last contact from intact family services worker was in October 2021, but the case was not officially closed in SACWIS until March 2022.
[5] CWS Holmes has a bachelor's degree in psychology and English, started with the Department in March 2021, and previously worked at a private agency as an Intact and Placement child welfare specialist for four years.
[6] PSA Booker has a master's degree in social work, started with the Department in 2011 as a child welfare specialist in Intact, and became a supervisor in November 2020.
[7] CWS Holmes and PSA Booker reported to OIG investigators that initial service recommendations are generally made by DCP, and additional services are determined throughout the life of the case.

reported that she was previously on Seroquel[8] and would like to take it again due to symptoms of anxiety. On July 1, PSA Booker noted that CWS Holmes completed a referral for a parent coach.

On July 8, CWS Holmes arrived at the shelter for a scheduled visit with Ms. Ball and Camille. Shelter staff informed CWS Holmes that Ms. Ball left the shelter with Camille several days prior and therefore domestic violence services had been halted. The staff could not provide CWS Holmes with Ms. Ball's whereabouts. CWS Holmes then went to the home of the maternal grandfather, Samson Ball, and observed Camille in Mr. Ball's care. Mr. Ball reported that he had taken Camille since he did not like where Camille and Ms. Ball had been staying after they left the shelter, but Mr. Ball did not know Ms. Ball's whereabouts. CWS Holmes completed a home safety checklist and noted the home to be appropriate. CWS Holmes made a call to the Hotline. During supervision on July 9, PSA Booker noted that Ms. Ball would be referred for a toxicology screening once she was released from jail.

SCR #2222222B July 8, 2021 – November 5, 2021
Allegation #60- Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to Camille Ball by Maria Ball- Indicated

On July 8, 2021, CWS Holmes reported to the Hotline that Ms. Ball had an open case due to substance abuse concerns and that Ms. Ball's older children were in foster care in another state. CWS Holmes reported that Ms. Ball came to Illinois to have Camille and to avoid the other state's child welfare services from taking custody of Camille. Ms. Ball and Camille had been residing at a local women's shelter. CWS Holmes went to visit them on July 8 and was informed that the family had left the shelter three days earlier. Ms. Ball dropped Camille off with a relative but the relative did not know where Ms. Ball was or when she would be returning.

The investigation was assigned to CPI Hera O'Neal,[9] supervised by PSA Myra Beckman.[10] In the initial supervisory staffing, PSA Beckman directed CPI O'Neal to speak with CWS Holmes to determine if there were "safety issues with the mother caring for the child—is there some additional concern because she left the shelter?"

CPI O'Neal spoke with CWS Holmes who reported that Camille was currently with the maternal grandfather, Mr. Ball. Mr. Ball reported to CWS Holmes that Ms. Ball left Camille with him, that Ms. Ball had been gone for a day, and he did not know her whereabouts.

CPI O'Neal went to the home of Samson Ball, the maternal grandfather. Mr. Ball reported that he had not been honest with CWS Holmes about knowing that Ms. Ball was in jail because he had not wanted Ms. Ball to get in trouble. Mr. Ball stated Ms. Ball was arrested and taken to jail, so Mr. Ball and his wife, Savannah Moon, went to pick up Camille. Mr. Ball expressed an ability to care for Camille and reported that he had spoken with a caseworker in the other state about having Ms. Ball's older children placed with him and Ms. Moon. CPI O'Neal observed Camille, who appeared healthy and was free of outward signs of abuse or neglect. CPI O'Neal observed Mr. Ball and Ms. Moon giving 6-week-old Camille Pedialyte and CPI O'Neal educated Mr. Ball and Ms. Moon on giving Camille formula only. CPI O'Neal documented that she would return to provide Camille with more formula and would also notify CWS Holmes of the

[8] According to Medlineplus.gov Seroquel (quetiapine) is an antipsychotic medicine mainly used in the treatment of schizophrenia and bipolar disorder. Though not recommended, it is sometimes used as a sleep aid. For anxiety, it may be used as an augmenting medicine to another medication.
[9] CPI O'Neal has a master's degree in science in child life, started with the Department in October 2021, and previously worked as a hospital child specialist for 10 years.
[10] PSA Beckman has a master's degree in human services and social work, started with the Department in 2013 as a child protection investigator, and became a supervisor in February 2021.

need for formula. Safe sleep arrangements were observed in the home. A CERAP staffing assessed Camille as Safe, and PSA Beckman wrote:

> Maria allegedly dropped off the baby and then turned herself into jail. She is not "missing" or using drugs as was alleged. There is no information to suggest that she cannot be around the baby. The narrative implied that she is not supposed to be around the baby due to other issues. She is supposed to have the baby but had left the children with the grandfather while she went to jail. More information needs to be obtained regarding her arrest, however there is no information to suggest the child would be unsafe. Safe sleep was noted and discussed.

The next day, July 9, CPI O'Neal received a call from Mr. Ball requesting assistance as Ms. Ball had been released from jail and arrived at Mr. Ball's home demanding Camille be returned to her. CPI O'Neal heard yelling in the background of the phone call and directed Mr. Ball to contact the police if necessary. CPI O'Neal went to Mr. Ball's home and observed Ms. Ball yelling and screaming at Mr. Ball and Ms. Moon. Police were also present, and CPI O'Neal went to a bedroom to speak with Ms. Ball. Ms. Ball was upset and reported that Mr. Ball and Ms. Moon were kicking her out and were not allowing Ms. Ball to take Camille. CPI O'Neal spoke with Ms. Ball about what would be best for Camille as Ms. Ball had no plan for where she would go. Ms. Ball agreed to allow Camille to remain with Mr. Ball and Ms. Moon for the weekend and stated that she would get Camille on Monday and that Mr. Ball and Ms. Moon "will never see the baby again." CPI O'Neal encouraged Ms. Ball to breathe and to not burn bridges. PSA Beckman reported to OIG investigators that a safety plan was not considered at this time as there was no evidence to suggest that Camille was unsafe. CPI O'Neal completed an oral toxicology with Ms. Ball, which was negative for all substances. CPI O'Neal notified CWS Holmes of the incident. PSA Beckman was notified, and CPI O'Neal was directed to "obtain any records from the other state." PSA Beckman told OIG investigators that although records should have been requested during the A-sequence, PSA Beckman wanted to re-request the records to determine if protective custody should be taken. CPI O'Neal reported to OIG investigators that records were requested but it took over a month for the records to be received as there are additional barriers in obtaining out of state records. Child protection staff did not receive the records from the other state until September 13, 2021.

On July 12, CWS Holmes met with Ms. Ball at a motel[11] where she was staying following her release from jail. Ms. Ball reported that Camille was staying with Mr. Ball and that she would remain with Mr. Ball until Ms. Ball was able to get "back on her feet," and have stable employment and housing. On July 13, CWS Holmes met with Camille at Mr. Ball's home. Mr. Ball reported that Ms. Ball had refused to give guardianship of Camille to Mr. Ball. Camille was observed, appeared healthy, and a bassinet for safe sleep was observed in the home.

On the evening of July 13, CWS Holmes received a call from Ms. Ball reporting that Mr. Ball had returned Camille to her, stating that he was unable to care for Camille without financial support. On July 21, CWS Holmes met with Ms. Ball and Camille at the motel. Ms. Ball reported that she had not gotten Camille's bedding from her father, and she had been placing Camille in her car seat to sleep. CWS Holmes offered to provide a pack and play but Ms. Ball reported that she just wanted to get the pack and play from Mr. Ball. CWS Holmes discussed safe sleep again and Ms. Ball denied that she allowed Camille to sleep in her bed with her and stated that "she knew she wasn't supposed to." CWS Holmes encouraged Ms. Ball to get Camille's bassinet from Mr. Ball as soon as possible and offered to go to Mr. Ball's home to obtain the pack and play. CWS Holmes explained that Ms. Ball would be referred for parenting services, counseling, and domestic violence services. CWS Holmes then called Mr. Ball and explained that Camille's sleeping equipment needed to be given to Ms. Ball, to which Mr. Ball agreed. CWS Holmes noted that Ms. Ball also needed assistance in obtaining her ID, birth certificate, and social security card. During supervision on July

[11] CWS Holmes reported to OIG investigators that CPI O'Neal informed him where Maria was staying.

21, PSA Booker noted Ms. Ball needed protective day care services as Ms. Ball had begun working at a restaurant and that CWS Holmes would assist Ms. Ball with obtaining appropriate housing.

On July 23, CWS Holmes picked up Camille's pack and play from Mr. Ball and delivered it to Ms. Ball. CWS Holmes asked Ms. Ball if she needed anything else, to which Ms. Ball replied "no." About one hour later, CWS Holmes was notified by the other state's caseworker that during a video call with Ms. Ball's older children, Ms. Ball was observed to be giving Camille water as she reported that she was out of formula. CWS Holmes made a call to the Hotline, which was taken as an emergency response due to ongoing concerns of Ms. Ball's ability to meet minimum parenting standards for a young infant. (See SCR #2222222C below).

SCR #2222222C July 23, 2021 – September 21, 2021
Allegation #76- Inadequate Food to Camille Ball by Maria Ball- Unfounded
On July 23, 2021, while the B-sequence investigation was pending, the Intact Family Services caseworker, CWS Holmes, called the Hotline to report the following:

> Reporter states he made a visit to drop off a pack and play to Maria (mother) for her infant daughter at around 3:30pm on 7/23/21. Maria has an open investigation with DCFS as well as an open intact case. Maria is also currently involved in CPS services in another state. At Reporter's visit he stated he asked Maria if she needed anything else and she said no so Reporter left. Reporter got a call shortly after from the other state's caseworker who had done an online visit with Maria and observed her feeding the infant only water. It was learned that Maria is only giving the child water and Pedialyte, not formula. Reporter contacted Maria and asked her if she had formula. She confirmed she was out of formula and also out of Pedialyte and said she was just giving the baby water. Maria has no plan to get formula and no options. Mother claimed that the store was out of formula. Reporter states that there are concerns that this child may need to be taken into PC due to the concerns going on with the mother. Reporter states he called and reported this initially but was advised by his supervisor to contact SCR and request an emergency response due to this child having no food at all at this present time and unclear when it was last provided substantial food. CFW clarified the mother is unable to feed the infant and the situation rises to the level of a new report.

On-call CPI Sherry Marley was assigned,[12] supervised by PSA Fabiola Long. CPI Marley spoke with CWS Holmes, who reported Ms. Ball received WIC but that she had not made her appointments due to not having transportation. CWS Holmes stated that he offered to drive Ms. Ball, but Ms. Ball refused. CPI Marley documented that CWS Holmes reported that CPI O'Neal notified him that custody would be taken of Camille, and she would be placed with the grandfather.

At 7pm on July 23, CPI Marley met with Ms. Ball and Camille in the motel where they were residing. CPI Marley noted the pack and play that CWS Holmes provided to Ms. Ball was still in the box. CPI Marley provided Ms. Ball with formula, distilled water, diapers, and clothing. CPI Marley prepared a bottle for Camille as Ms. Ball set up the pack and play. CPI Marley reported to OIG investigators that she did not ask Ms. Ball where Camille had been sleeping prior to the pack and play being assembled. Ms. Ball confirmed that she was out of formula and that she did not tell CWS Holmes this because she did not want to "get in trouble for not having formula."[13] Ms. Ball reported that she has not made her WIC appointments because she did not have her social security card or ID. CPI Marley explained that CWS Holmes can assist Ms. Ball and clarified that Intact services are in place in order for Ms. Ball to maintain custody of Camille. A CERAP

[12] CPI Marley has a bachelor's degree in psychology, started with the Department in 2017, and previously worked as a placement CWS with a private agency for four years.
[13] CPI Marley reported to OIG investigators that she did not ask Maria how long Camille had been without formula.

staffing occurred with PSA Long where Camille was assessed as Safe.[14] PSA Long noted that Camille had been "screaming and was clearly hungry and immediately took a bottle" upon CPI Marley's arrival.

The Intact supervisor, PSA Booker, documented a conversation with CWS Holmes, who reported that following the visit with Ms. Ball and Camille, CWS Holmes dropped his car off at the mechanic. CWS Holmes reported that on-call CPI Sherry Marley contacted CWS Holmes and "demanded" that CWS Holmes or PSA Booker meet her at her office. PSA Booker then spoke with CPI Marley who reported that "it was her opinion that the report should not have been made. CPI stated that it was her opinion that it was called in so that an investigator would take formula to the home rather than the intact worker having to take it." PSA Booker documented that CPI Marley went on to state that "this is a parenting issue" and recommended service providers for Ms. Ball to be referred.[15] PSA Booker attempted to explain to CPI Marley that there were larger concerns for Ms. Ball's ability to appropriately provide for Camille rather than Ms. Ball simply running out of formula. PSA Booker reported to OIG investigators that Ms. Ball's failure to utilize CWS Holmes as a resource and the choice to not be forthcoming about a need for her baby in order to prevent her from "getting in trouble" was concerning for Ms. Ball's ability to provide appropriate care for Camille. PSA Booker offered to assist CPI Marley with getting Camille formula which CPI Marley declined.

On July 27, PSA Booker noted that CWS Holmes received a message from Ms. Ball over the weekend stating that she needed assistance as she was unable to pay for the hotel where she and Camille were staying. CWS Holmes attempted to call both Ms. Ball and Mr. Ball to determine Camille's whereabouts but there was no answer. CWS Holmes left a message with CPI O'Neal and PSA Booker noted a staffing would be requested to discuss updates to the case.

CPI O'Neal was assigned as the primary investigator of the C-sequence investigation on July 26. CPI O'Neal met with Ms. Ball and Camille on July 28 and provided Ms. Ball with three cans of formula. On August 5, a staffing was held with CPI O'Neal, PSA Beckman, CWS Holmes, and Intact PSA Booker. Ms. Ball had moved into Blue Sky Shelter due to being unable to pay for a hotel room. Ms. Ball remained in Blue Sky Shelter for six days before being evicted due to lack of participation in required classes and moved back to Delta Refuge. According to Blue Sky Shelter staff, Camille was having problems taking a bottle while in their childcare. Ms. Ball reported that Camille was just upset to be in someone else's care and was "fine" after returning to Ms. Ball's care. It was noted that Ms. Ball was not doing what she had been asked to do, such as working with agencies to obtain her ID and birth certificate. PSA Beckman noted that although the tasks are menial, they are important because they are required to obtain housing, employment, or benefits. It was noted that Ms. Ball was providing the bare minimum of support to Camille and did not appear to take caring for the child seriously. PSA Beckman noted that on August 4, Ms. Ball was kicked out of the shelter where she and Camille were staying because Ms. Ball refused to follow the rules and went on a walk. Ms. Ball reported to CPI O'Neal that she had taken Camille on the walk with her and returned to Delta Refuge after being kicked out of BlueSky Shelter demonstrating a disregard for responsibility for Camille's needs. PSA Beckman directed CPI O'Neal and CWS Holmes to admonish Ms. Ball that if she cannot demonstrate a desire or commitment to ensuring that she has food and finding stable housing, then protective custody of Camille may be taken. In an interview with OIG investigators, PSA Beckman reported that although Ms. Ball's behavior was considered "high risk," the Department did not have "urgent and immediate" necessity to take protective custody. PSA Beckman and CPI O'Neal both reported to OIG investigators that Ms. Ball was not officially homeless and was meeting Camille's needs appropriately.

[14] No safety threats were identified on the CERAP.
[15] CPI Marley denied referring to this incident as a "parenting issue" to OIG investigators.

During the staffing, CWS Holmes was directed to inquire if Camille was seen by a doctor or not.[16] Ms. Ball still needed to obtain her birth certificate, ID, and social security card which would ensure Ms. Ball's ability to secure appropriate housing and receive WIC benefits to make sure that Ms. Ball has adequate formula for Camille. In addition, CWS Holmes was to complete a referral for homemaker services to assist with these tasks as well as provide transportation to necessary appointments. CWS Holmes reported to OIG investigators that he provided Ms. Ball with bus passes to assist with transportation and she declined additional transportation assistance offered by CWS Holmes.

On August 10, CPI O'Neal and CWS Holmes met with Ms. Ball at Delta Refuge. Ms. Ball agreed to go to WIC on August 11, stated that she had a counseling appointment for August 12, and agreed to comply with anger management, homemaker services, and parenting classes. Ms. Ball reported that she was previously prescribed Seroquel and Abilify for anxiety and agreed to follow up with a psychiatrist. On August 30, CPI O'Neal received police records which confirmed that Ms. Ball was arrested for domestic battery on July 8 following an incident where Ms. Ball argued and fought with another woman over money. It was noted that Ms. Ball's father, Samson Ball, took custody of Camille at the time of Ms. Ball's arrest.

During supervision on August 11, it was noted that Ms. Ball was engaged in domestic violence services through Delta Refuge and that Ms. Ball had acquired WIC services. CWS Holmes directed Ms. Ball to have service providers from the shelter contact CWS Holmes so that CWS Holmes could confirm Ms. Ball's cooperation in services.[17] CWS Holmes and CPI O'Neal met with Ms. Ball, who reported that she had formula but could use more. CWS Holmes and CPI O'Neal both reported to OIG investigators that Camille was regularly observed to appear well fed and developing appropriately for her age.

On September 1, CWS Holmes met with Ms. Ball and Camille and introduced the homemaker service provider[18] to Ms. Ball. CWS Holmes again explained that Ms. Ball needed to have Delta Refuge service providers contact CWS Holmes to confirm Ms. Ball's participation in services. CWS Holmes discussed the possibility that Ms. Ball may be asked to leave if she was not engaging in services. CWS Holmes confronted Ms. Ball that little to no progress has been made since case opening and explained that this would need to be staffed with PSA Booker. CWS Holmes completed a 90-day CERAP, identified no safety threats, and Camille was assessed safe. CWS Holmes again met with Ms. Ball and Camille approximately three weeks before Camille's death and CWS Holmes directed Ms. Ball again to have domestic violence and mental health service providers contact CWS Holmes to confirm Ms. Ball's participation and progress in services.[19] Ms. Ball reported that Delta Refuge would allow her and Camille to stay in the shelter for a few more weeks, at which point they would hold a review of Ms. Ball's case to address Ms. Ball's lack of compliance in group attendance. Ms. Ball reported that she was exploring housing in another town. CWS Holmes observed Camille and noted no concerns.

CPI O'Neal continued to meet with Ms. Ball and Camille through the conclusion of the B- and C-sequence investigations. In September, CPI O'Neal requested all records from Ms. Ball's case in the other state. CPI

[16] CPI O'Neal spoke with the primary care physician who reported that Camille was seen on June 29 for a well child exam but missed well child exams scheduled for August 3 and August 24, which resulted in Camille being behind on immunizations.

[17] CWS Holmes obtained DCFS consents but reported to OIG investigators that Delta Refuge does not accept DCFS consents and require their residents to sign Delta Refuge consents, which need to be updated every 30 days. CWS Holmes reported that Maria did not complete Delta Refuge consents to allow for CWS Holmes to receive information regarding Maria's progress.

[18] Private contractor to DCFS, Meredith Lang.

[19] CWS Holmes reported that Delta Refuge required clients to complete Delta Refuge consents in order to provide information and Maria did not sign Delta Refuge consents. CWS Holmes attempted to call Delta Refuge on multiple occasions and was told that information could not be released without Delta Refuge consents.

O'Neal also noted that two weeks prior to Camille's death, Ms. Ball reported to CPI O'Neal that she believed her older children should remain in their grandmother's care in the other state.

CWS Holmes received supervision two days after the last meeting with Ms. Ball and Camille. CWS Holmes reported that Ms. Ball had not participated in parenting services, that he could not verify Ms. Ball's engagement in domestic violence and mental health counseling, and that Ms. Ball may be asked to leave her current shelter in a few weeks. PSA Booker directed CWS Holmes to staff the case with the State's Attorney due to Ms. Ball's hesitation to cooperate with the Intact Family Services program. PSA Booker reported to OIG investigators that this was the first time a petition to the State's Attorney was considered as the Intact program usually allowed participants time to engage in services prior to referring the case to court. PSA Booker reported that it became apparent that Ms. Ball was unwilling or unable to comply with Intact recommendations and therefore court involvement would be required. PSA Booker noted that Ms. Ball's placement case in the other state was due in court the next week and CWS Holmes would request information from the caseworker in the other state regarding the outcome of the hearing.

CWS Holmes made continued efforts to meet with Ms. Ball and Camille and reached out to involved service providers who also reported that they had been unsuccessful in locating Ms. Ball since the last meeting with Ms. Ball and Camille. Approximately two weeks before Camille's death, another staffing was held with CPI O'Neal, PSA Beckman, CWS Holmes, and Intact PSA Booker and it was noted that Ms. Ball was about to be dismissed from another shelter due to noncompliance. Ms. Ball's extensive history with the Department was discussed and it was noted that Ms. Ball had not been compliant with taking Camille for well child exams or immunizations and having appropriate food for Camille. CWS Holmes was directed to refer the case to court. PSA Beckman directed that Camille would need to be taken for a physical exam as she was behind on regular care. PSA Beckman reported to OIG investigators that protective custody was not considered at this time as there were still no safety issues identified that would warrant protective custody. CPI O'Neal reported to OIG investigators that although Ms. Ball was not making progress and was inconsistent with services, there was no urgent or immediate threat identified to justify taking protective custody of Camille.[20]

The next day, CPI O'Neal received a call from Ms. Ball after ongoing attempts to contact her, and Ms. Ball reported that she had returned to Delta Refuge. Ms. Ball reported that her phone had broken, and she was not trying to avoid CWS Holmes or service providers. CPI O'Neal transported Ms. Ball and Camille for a wellness exam at an urgent care clinic for Camille, who was noted to be in the 91st percentile for height and weight and no concerns were identified by the doctor. Camille was referred to follow up with a primary care physician to bring Camille up to date with immunizations and well child exams. Ms. Ball reported to CPI O'Neal that she would be forced to leave Delta Refuge due to not attending group sessions but that she was not given a specific date of when she would be required to leave. In an interview with OIG investigators, CPI O'Neal reported that Ms. Ball had stated that she wanted to obtain housing on her own but also spoke of a connection with a church that may be able to assist with housing.[21] CPI O'Neal informed Ms. Ball that a referral had been made to court as Ms. Ball had not engaged in services and again reiterated the need for Ms. Ball to engage in services. CPI O'Neal then spoke with CWS Holmes to update him on Camille's medical exam.

In a final child protection supervisory note nine days before Camille's death, PSA Beckman noted that although Ms. Ball had run out of formula and had been giving Camille water and Pedialyte, Camille was

[20] PSA Beckman and CWS Holmes both spoke of challenges with court referrals in their interviews with OIG. It was reported that the court is dealing with an especially high number of cases and referrals, and it can take up to six months from the time the court referral is filed to getting a first appearance date.

[21] CPI O'Neal did not obtain information regarding the housing option through the church and reported to OIG investigators that she was unaware of what CWS Holmes was doing in order to address housing with Maria.

not in any distress and was overall healthy. Additionally, although they did not know how long Ms. Ball was not giving Camille formula, Camille was assessed by a medical professional and was found to be in the 91st percentile, so the lack of food at least for that day/moment did not appear to have been significant enough to impact the child. CPI O'Neal and CPI Marley both reported to OIG investigators that Ms. Ball was not directly asked how long she had been without formula for Camille, and it was determined that the incident did not rise to the level of neglect as it was identified and addressed quickly. The C-sequence investigation was unfounded, and Ms. Ball was directed to continue to comply with the Intact Family Services program. CPI O'Neal reported to OIG investigators that the decision was made to unfound and close the C-sequence investigation because "it was an educational issue" that had been corrected. CPI O'Neal reported that a decision was made to keep the B-sequence open in order to receive and review the records from the other state and that the allegations in the B-sequence investigation were "more pressing."

Continued Intact Case
The day after the child protection investigation closed, Ms. Ball completed a toxicology screening as was referred by CWS Holmes. The screening was positive for marijuana and negative for all other substances. During supervision the next day, PSA Booker documented that Ms. Ball needed to reengage with the homemaker as Ms. Ball missed three consecutive appointments and that CWS Holmes had sent a referral to Blacksmith County State's Attorney. CWS Holmes documented additional ongoing attempts to contact Ms. Ball to schedule visits, which Ms. Ball did not answer or reply. Five days later, Ms. Ball texted CWS Holmes to inform him that she was out of town for a funeral and CWS Holmes explained that they needed to schedule a visit as CWS Holmes needed to see Camille.

Two days after CWS Holmes received the text from Ms. Ball, it was reported to the Hotline that Camille had died. (See SCR #2222222D below.)

CWS Holmes noted he had directed Ms. Ball to notify him if she moved, as CWS Holmes would be required to assess the living environment and ensure Ms. Ball had appropriate sleeping arrangements for Camille. CWS Holmes noted that he did not know Ms. Ball had moved until being notified of Camille's death.

The B-sequence child protection investigation was closed after the death. In November, a final supervisory note stated that the investigation would be indicated as there were concerns for Ms. Ball's ability to care for Camille. Ms. Ball left Camille with the grandfather and "disappeared," and her other children had been previously removed from her care in another state. Police records obtained by CPI O'Neal indicated that Ms. Ball was involved in a domestic violence incident at a hotel in July 2021 with Camille present. Ms. Ball was arrested and failed to cooperate with the Intact Family Program. PSA Beckman noted that "while this report was pending, another report was called in after the baby had been found deceased due to alleged unsafe sleep conditions."

DEATH
SCR #2222222D September 2021 – December 2021
Allegation #51- Death by Neglect to Camille Ball by Maria Ball- Indicated

It was reported to the Hotline that 4-month-old Camille was pronounced dead at the hospital. Ms. Ball and Camille had moved into a room of a home owned by a local church several days prior. The reporter stated that Camille was co-sleeping with her mother and fell between the edge of the mattress and the wall. It is unknown when Ms. Ball contacted EMS. An EMS ambulance transported Camille to the hospital, where she was pronounced deceased. It was noted that Ms. Ball has two older children in DCFS custody.[22]

[22] The reporter did not clarify if the older children in care were in Illinois or the other state.

During an initial staffing, the supervisor noted that Ms. Ball had been provided with two pack and plays for Camille, one by CPI O'Neal during the B-sequence and another by Intact CWS Holmes. Both the child protection investigator and the Intact child welfare specialist documented discussing safe sleep practices with Ms. Ball on numerous occasions. Assigned CPI Bill Lerner[23] went to the hospital to observe the child victim. CPI Lerner noted that Camille had no notable outward signs of physical abuse and that life saving measures were attempted by both the responding EMTs and the hospital medical staff. CPI Lerner spoke with a hospital nurse who reported that Camille arrived at the hospital at 8:26am unresponsive and the last time Camille was seen alive was at midnight. The nurse noted that Ms. Ball appeared nonchalant but became emotional when she found out that Camille was deceased.

CPI Lerner completed a scene reenactment with Ms. Ball who reported that she had traveled out of town the day prior, returned late in the evening, smoked marijuana, taken a couple shots, and then drank more prior to going to sleep with Camille. Ms. Ball reported that she placed Camille on her stomach in Ms. Ball's bed, laid down next to Camille with her back to Camille, and awoke to find that Camille was wedged between the mattress and wall. Ms. Ball pulled Camille out and called 911. CPI Lerner observed a pack-and-play in its carrying case in the bedroom closet, but the mattress was missing. CPI Lerner completed an oral toxicology screening with Ms. Ball, which was positive for marijuana and negative for all other substances.

CPI Lerner obtained medical records, police reports, case files for Ms. Ball's child welfare case in another state, and spoke with the intact worker, collaterals, and witnesses. There was no evidence obtained to suggest foul play or any medical conditions that would have led to Camille's death. Ms. Ball had been educated by intact workers and child protection investigators regarding safe sleep on numerous occasions and had been provided a pack and play by the Department. Ms. Ball admitted to co-sleeping and said that she knew she was not supposed to. Ms. Ball was indicated for Allegation 51 – death by neglect due to her blatant disregard for Camille by not taking reasonable, precautionary measures to ensure her safety.

ANALYSIS

A determination that a child should be removed from their parent should only be made if there is reason to believe that leaving the child in the care and custody of the parent presents an immediate safety threat to the child, even if services are provided to the family. Camille's mother had a significant history with another state's child protective services dating to 2016, which included her two older children being removed from her care in September 2019. She was not compliant with services and her case was moving towards termination of parental rights. In April 2020, prior to Camille's birth, her mother fled from the other state and moved to Illinois, presumably to avoid Camille from being taken into custody. The Department failed to use the mother's history in the other state in assessing the current situation. In the four months that the mother was in Illinois, she showed little stability and was involved in three child protection investigations. Each time, the infant was assessed as safe, and it was determined that there was not "urgent and immediate" necessity to remove Camille from her mother's care.

The first investigation involving this family opened June 3, 2021, after another state's child protective services investigator reported to the Hotline that the mother fled to Illinois to give birth after she was informed that her newborn would need to be seen and assessed. CPI Majors, the assigned DCFS child protection investigator, spoke to the reporter and to the mother's placement caseworker from the other state that day, who both expressed serious concerns for the safety of the new baby due to the mother's unaddressed mental health and substance abuse issues. The other state's placement worker told CPI Majors that the mother had not followed through with any recommended services including mental health treatment, substance abuse evaluation, parenting services, and maintaining adequate housing and

[23] CPI Lerner is no longer a child protection investigator and currently works for the DCFS Office of the Inspector General.

employment. In addition, the mother was currently on probation in another state for assault of a family member. The other state's worker said that Camille would have been taken into custody if she had been born in that state.

The next day, CPI Majors located the mother and newborn at a shelter. The mother told the investigator that she came to Illinois because there were no resources to help her in the other state. She confirmed her two older children were in foster care and said she was unable to complete recommended services due to transportation issues. The mother reported she completed a psychological evaluation but did not know mental health treatment and medication had been recommended. She admitted to being on probation for assaulting a family member and reported that her probation officer did not know that she was in Illinois. The mother reported working with the shelter to obtain stable housing. The investigator completed a SAFE CERAP noting "the mother does have an open placement case in another state but failed to get the support from her placement worker to get back on her feet," and the mother agreed to intact family services.

In child protection investigations, the child protection investigator must assess and weigh all the evidence gathered during the investigation. While uncertainty in child protection is unavoidable, information sharing between professionals is key to valid risk assessment and should result in better decision-making. In this case, the other state's child welfare professionals shared ample information with DCFS about the mother's case history, lack of compliance, and current concerns for Camille's safety. Additionally, they reported that had Camille been born in the other state, she would have come into care. Despite this, DCFS did not take protective custody and allowed Camille to remain in her mother's care and opened an intact family services case. The mother's self-report was seemingly given more weight in this decision-making process than child welfare professionals, who arguably have no ulterior motives to distort the facts unlike parents who may have powerful motives to misconstrue information.

Additionally, a court in another state had removed the mother's two older children in 2019 and determined that they had been abused and/or neglected. The mother was not compliant with services and the case was moving towards termination of her parental rights. When any court finds that it is necessary to remove a child from the parent's care due to abuse or neglect, there should be a presumption that the same risks exist for any other minor in the care of that parent who has not made progress in correcting the reasons for child welfare involvement.

Risks can change as circumstances change and should be assessed on an ongoing basis. Information gathering is a continual process, with new information needing to be incorporated with what is already known. The new information requires a review of past decisions and a reassessment of risk of harm. Critical analysis of the new information needs to occur in order to determine its significance for the safety of the child. In the four months that the mother was in Illinois, she demonstrated little stability and was uncooperative with intact services. During this time, the mother regularly moved between shelters, motels, and relatives without notifying the intact worker; was terminated from services because she no longer resided at the shelter; was arrested for a domestic incident involving another woman; and was observed feeding Camille water and Pedialyte, while admitting to not having formula despite being eligible for WIC. Based on these new concerns, the intact worker made two additional Hotline calls - the first three weeks after the intact case opened and the second two weeks after that.

During the subsequent child protection investigations, the Department had an opportunity to revise their initial risk assessment and correct their faulty logic relied upon during the initial investigation. Instead, the faulty logic guided future decisions, and in both investigations, it was determined that Camille remained safe in her mother's care. CWS Holmes first contacted the Hotline after learning that the mother and infant were no longer residing in the women's shelter. The assigned investigator, CPI O'Neal, was instructed by her supervisor to speak with CWS Holmes to determine if there were safety issues with the mother caring for the child and if there were additional concerns because she left the shelter. That day, CPI O'Neal

observed the 6-week-old infant in the care of her maternal grandfather, who was caring for the infant while the mother was in jail. While this investigation was pending, the intact worker called the Hotline for a second time after receiving a call from the other state's caseworker who had done an online visit with mother and observed her feeding the infant only water.

When assessing risk to a child, if the family has an open services case with the Department, the child protection specialist must consider the degree of parental cooperation with services and the extent to which the provided services address the current allegation. This family had open child welfare cases, a placement case in another state and an intact case in Illinois, and the mother was not cooperative with either. Rather than focusing on the outcome, assessments of decisions should concentrate on whether they were reasonable and appropriate for the circumstances existing at the time. The Department ignored information that supported a decision to remove the infant from the mother's care. The information was readily available that the mother had a history of not cooperating with child welfare services and posed a risk to her children due to her untreated mental health and substance abuse issues.

Within five weeks of the intact case opening, the intact worker had called the Hotline twice because of the mother's instability. The intact caseworker and the intact supervisor recognized that the risks to the infant continued and heightened as the intact case continued. They communicated their concerns about the mother's ability to care for her infant to the child protection investigator and supervisor. However, the child protection team believed they did not have enough information to take protective custody of the infant citing lack of urgent and immediate necessity. Intact staff also communicated with the other state's child welfare staff, who expressed their continued concerns about the mother's ability to care for the infant. The mother was not meeting minimal parenting standards. The intact worker and supervisor worked with child protection to provide the mother with formula and pack and plays and attempted to address her housing instability. The investigations remained pending, and the intact worker continued to struggle with engaging the mother in services for two months before Camille died.

RECOMMENDATIONS

1. CPI Coral Majors should receive non-disciplinary counseling. As part of the counseling session, this report should be reviewed and discussed with Ms. Majors.

2. Yolanda Barnes should receive non-disciplinary counseling. As part of the counseling session, this report should be reviewed and discussed with Ms. Barnes.

3. CPI Hera O'Neal should receive non-disciplinary counseling. As part of the counseling session, this report should be reviewed and discussed with Ms. O'Neal.

4. PSA Myra Beckman should receive non-disciplinary counseling. As part of the counseling session, this report should be reviewed and discussed with Ms. Beckman.

5. This report should be shared with the Area Administrator for use in supervision with child protection staff.

6. This report should be shared with Intact Family Services Caseworker Marcus Holmes for training purposes.

7. This report should be share with Intact Family Services Supervisor Leslie Booker for training purposes.

8. This report will be used by OIG in Error Reduction training on decision making practices in child protection.