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

**REPORT TO THE GOVERNOR
AND THE GENERAL ASSEMBLY**

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OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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To Governor Blagojevich and Members of the General Assembly:

This summer, following hearings by the House Committee on DCFS Oversight, several pieces of legislation were passed tackling current child welfare problems. Public Act 95-0405, which will be effective June 2008, allows child protection investigators and intact family caseworkers to request a Juvenile Court order of protection when a parent, guardian or custodian's cooperation with critical services, such as substance abuse or mental health treatment, is necessary for the safety and welfare of a child. The use of graduated sanctions has been successful in drug courts throughout the state and is a welcome application to child welfare cases. Public Act 95-0527 authorizes the Office of the Inspector General to develop Error Reduction Implementation Plans, providing a feedback loop to the field of lessons learned through the Inspector General's death and serious injuries investigations and Illinois Child Death Review Team Recommendations.

The spirit of both Public Acts represents a concerted effort to remedy problems by harnessing the knowledge and collective wisdom gathered over time by those entrusted to review child deaths and serious injuries. Members of the child death review teams, state's attorneys, local coroners and medical examiners have and can assist in providing pro bono targeted trainings to state and private agency child welfare professionals. It takes rolling up our sleeves and hitting the trail with the lessons learned.

A major obstacle to this effort is the present situation of high caseloads and inadequate staffing in child protection and intact family teams. For example, the Department of Children and Family Services' most recent administrative data shows that there is an error prone situation with almost two-thirds of the child protection workers in the Metro-East St. Louis area carrying higher investigation caseloads than the agreed upon count established in the settlement of the federal court case known as B.H. Since investigative basics include the painstaking tasks of gathering critical information – the who, what, where, when and how of injuries – errors will be made without sufficient time to collect this information. Without adequate supervision, errors will not be caught before the investigation is closed. One-third of the Metro-East St. Louis investigation teams have supervisory vacancies. This situation is not unique to the Metro-East St. Louis region; other regions face the same error prone situation. All the collective wisdom and trainings cannot remedy this situation. It will take a firm commitment from all involved to peel back the bureaucratic red tape that bogs down the hiring process.

I hope that by June, when Public Act 95-0405 and Public Act 95-0527 are effective, the Department is in compliance with B.H., so that the specific behaviors required by the Error Reduction Implementation Plans can be realized.

Again, I would like to thank the House Committee on DCFS Oversight for the opportunity to appear before it. My remarks to the committee are found on page 154.

Respectfully,



Denise Kane, Ph.D.
Inspector General

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

TABLE OF CONTENTS

INTRODUCTION.....	1
Investigation Categories.....	1
Investigative Process.....	3
Reports.....	4
Additional Responsibilities.....	5
INVESTIGATIONS.....	7
Death and Serious Injury Investigations.....	7
Child Death Report.....	33
Summary.....	34
Homicide.....	39
Suicide.....	48
Undetermined.....	48
Accident.....	56
Natural.....	70
Seven-Year Death Retrospective.....	89
General Investigations.....	93
Systems Investigations.....	131
OIG INITIATIVES.....	153
Legislation.....	153
Immigration Education Initiative.....	159
Ethics.....	161
Home and Fire Safety Training.....	161
Case Conferencing for Parenting Teen Wards.....	162
Older Caregivers.....	162
SYSTEMIC RECOMMENDATIONS.....	165
RECOMMENDATIONS FOR DISCIPLINE AND CONTRACT TERMINATION.....	175
LAW ENFORCEMENT CASES.....	181
DEPARTMENT UPDATE ON PRIOR RECOMMENDATIONS.....	183
APPENDICES:.....	207
Sacha Webber Investigation.....	Appendix A
Caleb Thomas Death Investigation.....	Appendix B

INTRODUCTION

The Inspector General was created by unanimous vote of the Illinois General Assembly in June 1993 to reform and strengthen the child welfare system. The mandate of the Office of the Inspector General (OIG) is to investigate misconduct, misfeasance, malfeasance, and violations of rules, procedures, or laws by Department of Children and Family Services employees, foster parents, service providers and contractors with the Department. See 20 ILCS 505/35.5 and 35.6. To that end, this Office has undertaken numerous investigations and initiated projects designed to uncover wrongdoing, improve practice, and increase professionalism within the Department. The value and focus of the OIG is on the individual life of the child.

INVESTIGATION CATEGORIES

Death and Serious Injury Investigations

The Office of the Inspector General investigates deaths and serious injuries of Illinois children whose families were involved in the child welfare system within the preceding twelve months. The OIG is also a member of Child Death Review Teams around the state. The Inspector General is an *ex officio* member of the Child Death Review Team Executive Council. The OIG receives notification from the Illinois State Central Register (SCR) of all child deaths and serious physical injuries where the child was a ward of DCFS, the family was the subject of an open investigation or service case, or the family was the subject of an investigation or case within the preceding twelve months. The notification of a child death or serious injury generates a preliminary investigation in which the death report and other reports are reviewed and computer databases are searched. When further investigation is warranted, records are impounded, subpoenaed or requested and a review is completed. When necessary, a full

investigation, including interviews, is conducted. The Inspector General's Office created and maintains a database of child death statistics that compiles critical information related to child deaths in Illinois. The following chart summarizes the death cases reviewed in FY 07:

FY 07 CHILD DEATH CASES REVIEWED

CHILD DEATHS IN FY 07 MEETING THE CRITERIA FOR REVIEW	111
PRELIMINARY INVESTIGATIONS CONDUCTED	7
INVESTIGATORY REVIEWS OF RECORDS	75
FULL INVESTIGATIVE REPORTS SUBMITTED TO DCFS	6
FULL INVESTIGATIONS PENDING	23

Summaries of death investigations, with a full investigative report submitted to the Director, are included in the Investigations section of this Report. See page 33 for a summary of all child deaths reviewed by the OIG in FY 07.

General Investigations

The Office of the Inspector General responds to and investigates complaints filed by the state and local judiciary, foster parents, biological parents and the general public. At the request of the Director or when the OIG has noticed a particularly high level of complaints in a specific segment of the child welfare system, the OIG will conduct a systemic review of that segment. Investigations yield both case-specific recommendations and recommendations for systemic changes within the child welfare system. The Inspector General's Office monitors compliance with all recommendations.

Child Welfare Employee Licensure Investigations

In 2000, the General Assembly mandated that the Department of Children and Family Services institute a system for licensing child welfare employees. The Child Welfare License permits centralized monitoring of all persons providing direct child welfare services, whether they are employed with the Department or a private agency. The employee licensing system seeks to provide accountability, integrity and honesty from those entrusted with the care of vulnerable children and families. In an opinion recommending license revocation, the Administrative Law Judge recognized the critical role that honesty plays for child welfare professionals:

Integrity and honesty are critical to effective child welfare practice. A direct child welfare worker is not only an advocate for the clients served, but also a witness and agent for the court. In order to ensure that correct decisions are made to protect the welfare and safety of a child, the child welfare system is dependent upon the veracity of information received. There must be zero tolerance for breaches of trust. A direct child welfare worker's word must be above reproach: if they say it happened, it happened; and, if it didn't happen, then it didn't happen. Actual harm or injury to a child is not a prerequisite for immediate corrective action.

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

A committee composed of representatives of the OIG, the Child Welfare Employee Licensure Board and the Department's Office of Employee Licensure screens referrals for CWEL Investigations. The committee reviews complaints to determine whether the allegations meet one or more grounds for licensure action as defined in Department Rule 412.50 (89 Ill. Adm.

Code 412.50). The OIG investigates and prosecutes CWEL complaints and hearings.

When a CWEL Investigation is completed, the OIG, as the Department's representative, determines whether the investigation supports a basis for possible licensure action. Allegations that could support licensure action include conviction for specified criminal acts, indicated findings of child abuse or neglect, egregious acts that demonstrate incompetence or a pattern of deviating from a minimum standard of child welfare practice. Department Rule 412.50 (89 Ill. Reg. 412.50) specifies the grounds for licensure action. When licensure action is appropriate, the licensee is provided an opportunity for a hearing. An Administrative Law Judge presides over the hearing and reports findings and recommendations to the Child Welfare Employee Licensure Board. The CWEL Board makes the final decision regarding licensure action.

In FY 07, 11 cases were referred to the Inspector General's Office for Child Welfare Employee License investigations and one investigation was opened from the prior year. In addition, the Inspector General's Office provided technical assistance to the Office of Employee Licensure in 6 cases, and monitored pending criminal or abuse/neglect charges in 22 cases. The following chart reports disposition of the 11 cases investigated in FY 07 and pending investigations:

FY 07 CWEL Investigation Dispositions

CASES OPENED FOR FULL INVESTIGATION	11
LICENSE VOLUNTARILY RELINQUISHED DURING INVESTIGATION	1
LICENSURE CHARGES ISSUED	8
Voluntarily Relinquished after Charges	3
Case Pending in the AHU	1
ALJ Recommendations to Revoke *	2
Final Revocation	2
PENDING INVESTIGATIONS	2
CASES PENDING PRIOR TO 2007	2
PENDING BEFORE THE AHU	1
CHARGES ISSUED AND LICENSE REVOKED	1

* Pending Board Action

Criminal Background Investigations and Law Enforcement Liaison

The Inspector General's Office provides technical assistance to the Department and private agencies in performing and assessing criminal history checks. In FY 07, the Inspector General's Office opened 2,066 cases requesting criminal background information from the Law Enforcement Agencies Data System (LEADS). Each case may involve multiple law enforcement database searches. For the 2,066 cases opened in FY 07, the OIG conducted 8,242 searches for criminal background information. In addition, in the course of an investigation, if evidence indicates that a criminal act may have been committed, the Inspector General may notify the Illinois State Police, Attorney General or other appropriate law enforcement agency or it may investigate the alleged act for administrative action only. The Office of the Inspector General assists enforcement agencies with gathering necessary documents. If a law enforcement agency elects to investigate and requests that the administrative investigation be put on hold, the Office of the Inspector General will retain the case on monitor status. If a law enforcement agency declines to prosecute, the OIG will determine whether administrative action is appropriate.

INVESTIGATIVE PROCESS

The Inspector General's Office investigative process begins with a Request for Investigation or notification by the State Central Register of a child's death or serious injury. Investigations may also be initiated when the OIG learns of a pending criminal (or child abuse investigation for referral to CWEL) against a child welfare employee. In FY 07, the OIG received 2,403 Requests for Investigation.¹ Requests for Investigation and notices of deaths or serious injury are screened to determine whether the facts suggest possible misconduct by a

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

Department employee, private agency employee or foster parent, or whether there is a need for systemic change. If an allegation is accepted for investigation, the Inspector General's Office will review records and interview relevant witnesses. The Inspector General reports to the Director of the Department and to the Governor with recommendations for discipline, systemic change, or sanctions against private agencies. The Office of the Inspector General monitors the implementation of accepted recommendations.

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

The Office of the Inspector General is mandated by statute to be separate from the Department. OIG files are not accessible to the Department. The investigations and the Investigative Reports and Recommendations are prepared without editorial input from either the Department or any private agency. Once a Report is completed, the Inspector General will consider comments received and the Report may be revised accordingly.

If a complaint is not appropriate for full investigation by the OIG, the OIG may refer the complaint to law enforcement (if criminal acts appear to have been committed), to the Department's Advocacy Office for Children and Families, or to other state regulatory agencies such as the Department of Professional Regulations.

Administrative Rules

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

employee licensure action are found at 89 Ill. Admin. Code 412.

Confidentiality

A complainant to the Office of the Inspector General, or anyone providing information, may request that their identity be kept confidential until an investigation is concluded. If possible, the Office of the Inspector General will attempt to procure information from another source. The OIG and the Department are mandated to ensure that no one will be retaliated against for making a good faith complaint or providing information in good faith to the OIG. At the same time, an accused employee needs to have sufficient information to enable that employee to present a defense.

Office of the Inspector General reports contain various types of information that are confidential pursuant to both state and federal law. As such, OIG Reports are not subject to the Freedom of Information Act. The OIG has prepared several reports deleting confidential information for use as teaching tools for private agency or Department employees.

Impounding

The Office of the Inspector General is charged with investigating misconduct "in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution." In order to conduct thorough investigations, while at the same time ensuring the integrity of records, investigators may impound files. Impounding involves the immediate securing and retrieval of original records by the OIG. When files are impounded, a receipt for impounded files is left with the office or agency from which the files are retrieved. Critical information necessary for ongoing service provision may be copied during the impound in the presence of the OIG investigator. Impounded files are returned as soon as practicable. However, in death investigations the OIG forwards original files to the Department's Division of Legal Services to ensure that the Department maintains a central file.

REPORTS

Office of Inspector General reports are submitted to the Director of DCFS and the Governor, through the Governor's designee, the Office of the Executive Inspector General. An Inspector General report contains a summary of the complaint, a historical perspective on the case, including a case history, and detailed information about prior DCFS or private agency contact with the family. An analysis of the findings is provided, along with recommendations.

The Office of the Inspector General uses some reports as training tools. The reports are redacted to ensure confidentiality and then distributed to private agencies, schools of social work, and DCFS libraries as a resource for child welfare professionals to provide prudent professionals a venue for an ethical discussion on individual and systemic problems within the practice of child welfare. Redacted OIG reports are available from the OIG by calling (312) 433-3000.

Recommendations

In her investigative reports, the Inspector General may recommend systemic reform or case specific interventions. Systemic recommendations are designed to strengthen the child welfare system to better serve children and families.

Ideally, discipline should be constructive in that it serves to educate an employee on matters related to his/her misconduct. However, it must also function to hold employees responsible for their conduct. Discipline should have an accountability component as well as a constructive or didactic one. Without the accountability component, there is little to deter misconduct. Without the didactic component, an employee may conclude that s/he has simply violated an arbitrary rule with no rationale behind it.

The Inspector General presents recommendations for discipline to the Director

of the Department and, if applicable, to the Director and Board of the private agency. The Office of the Inspector General monitors implementation of recommendations for disciplinary action. Recommendations for discipline are subject to due process requirements. In addition, the OIG will determine whether the facts suggest a systemic problem or an isolated instance of misconduct or bad practice. If the facts suggest a systemic problem, the Inspector General's Office may investigate further to determine appropriate recommendations for systemic reform.

When recommendations concern a private agency, appropriate sections of the report are submitted to the Director and the Board of Directors of that agency. The agency may submit a response to address any factual inaccuracies in the report. In addition, the Board and agency Director are given an opportunity to meet with the Inspector General to discuss the report and recommendations.

In this Annual Report, systemic reform recommendations are organized into a format that allows analysis of recommendations according to the function within the child welfare system that the recommendation is designed to strengthen. The Inspector General's Office is a small office in relation to the child welfare system. Rather than address problems in isolation, the OIG views its mandate as strengthening the ability of the Department and private agencies to perform their duties.

The Office of the Inspector General monitors implementation of recommendations made to the Director of DCFS and private agencies. Monitoring may take several forms. The OIG may monitor to ensure that Department or private agency staff implements the recommendations made or may work directly with the Department or private agency to implement recommendations that call for systemic reform. The OIG may also develop accepted reform initiatives for future integration into the Department.

ADDITIONAL RESPONSIBILITIES

OIG Hotline

Pursuant to statute, the Office of the Inspector General operates a statewide, toll-free telephone number for public access. Foster parents, guardians *ad litem*, judges and others involved in the child welfare system have called the hotline to request assistance in addressing the following concerns:

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

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

The following chart summarizes the Office of the Inspector General's response to calls received in FY 07:

CALLS TO THE OIG HOTLINE IN FY 07

INFORMATION AND REFERRAL	1036
REFERRED TO SCR HOTLINE	85
REFERRED FOR OIG INVESTIGATION	129
TOTAL CALLS	1250

Ethics Officer

The Inspector General is the Ethics Officer for the Department of Children and Family Services. The Inspector General reviews Ethics Statements for possible conflicts of interest of those employees of the Department of Children and Family Services who are required to file Ethics Statements.

For FY 07, 673 Statements of Economic Interest were submitted to the Ethics Officer. Of the 673 submitted, 89 indicated potential conflicts of interest. The 89 were further reviewed and 15 advisory letters were sent to employees notifying them of steps to take to avoid conflicts of interest between their outside activities and their state employment.

OIG ACTION ON FY 07 STATEMENTS OF ECONOMIC INTEREST

ECONOMIC INTEREST STATEMENTS FILED	673
STATEMENTS INDICATING POSSIBLE CONFLICTS	89
ADVISORY LETTERS SENT TO EMPLOYEES	15

The OIG Ethics staff also coordinated DCFS compliance of the statewide ethics training mandated under the Illinois State Officials and Employees Ethics Act of 2003. In FY 2007, 3,133 employees were trained.

Consultation

The Office of the Inspector General staff provided consultation to the child welfare system through review and comment on proposed rule changes and through participation on various ethics and child welfare task forces.

OIG Project Initiatives

Informed by the Office of the Inspector General investigations and practice research, the Project Initiatives staff assist the Department's Division on Training in the development of practice training models for caseworkers and supervisors. The model initiatives are interdisciplinary and involve field-testing of strategies. The initiatives are evaluated to ensure the use of evidence-based practice and to determine the effectiveness of the model. See page 153 of this Report for a full discussion of the current initiatives.

INVESTIGATIONS

This annual report covers the time from July 1, 2006 to June 30, 2007. The Investigations section has four parts. Part I includes summaries of child death and serious injury investigations reported to the Department Director and the Executive Inspector General. Part II contains aggregate data about and case summaries of child deaths in families who were involved with the Department in the preceding 12 months. Part III contains general investigation summaries conducted in response to complaints filed by the state and local judiciary, foster parents, biological parents and the general public. Part IV contains recommendations related to systems issues identified by the Inspector General during the previous year.

Investigation summaries contain sections detailing the allegation, investigation, OIG recommendations and Department response. For some recommendations, OIG comments on the Department's responses are included in italics in the "OIG Recommendation/Department Response" section of each case.

DEATH AND SERIOUS INJURY INVESTIGATIONS

DEATH AND SERIOUS INJURY INVESTIGATION 1

ALLEGATION

An 11 year-old boy died of blunt force trauma to the head suffered while in the home of his adoptive mother. At the time of his death, six earlier investigations of physical abuse of the boy had been conducted and a seventh was pending.

INVESTIGATION

The boy had been placed in the home four years earlier and was adopted by the mother ten months later. The first investigation of abuse was initiated two months afterwards when the boy showed up at school with scratches on his face, neck and back. The boy stated he had been injured by "someone from home," later explaining he'd been hurt while roughhousing with his adoptive brother, who was five years older. One week later, a second report was made when the boy arrived at school with bruises on his face and bite marks on his back. The boy, the mother and the brother all stated the bruises were caused when he had tripped and hit his face against a chair. The boy said the bites had been caused by a schoolmate, but school staff stated the incident could not have occurred there given the degree of supervision at the small institution. The allegation was indicated against an unknown perpetrator.

Ten months passed before another report was made, the first of three to be accepted during a four-month span. The second of these incidents, the fourth overall, was related to a severe beating the boy received from his aunt, his brother and a cousin, while the other two events were similar to the earlier reports of suspicious facial abrasions, bruises and scratching. Because the allegations were made during such a short period of time, all three were handled by the same child protection investigator. In conducting his work, the child protection investigator demonstrated a poor understanding of the tenets of thorough investigative process and an inability to view information objectively. Parties with direct involvement in the incidents, including the cousin who participated in the beating, the nurse who treated the boy in the emergency room that he confided in or the police officers who investigated the assault, were not interviewed. The mother's repeated assertions that the boy was clumsy, accident-prone and withdrawn were accepted without critical assessment, despite comments from teachers describing him as an outgoing, personable child who was steady on his feet. The repeated explanations that the boy's injuries were the result of horseplay with the brother, who was more than a foot taller and outweighed the boy by almost 150 pounds, were not considered in regards to the boy's willingness or safety as a participant. The issue of how often the brother served as the boy's primary

caretaker, given the mother's extensive work hours, was never explored. An untitled, unattributed child summary, completed at the time of the boy's adoption, referenced his supposed predilection for self-injury and mutilation and was frequently presented by the mother as "medical evidence" he was responsible for the majority of his injuries. Notes in the case record pertaining to counseling the boy received during the same time the summary was completed were lacking in substance and provided little tangible insight into his state of mind or disposition.

The beating inflicted by the boy's adoptive relatives, during which he was whipped with a belt, hit in the head with an iron and struck with fists, commenced after the mother authorized the aunt over the phone to discipline him and resulted in his being taken to a hospital emergency room with serious injuries. The mother refused to provide either the investigator or law enforcement with the aunt's address or other contact information, stating she did not want other members of her family subjected to Department involvement. This defiant position was accepted by the investigator and supported by the investigator's supervisor, who told the OIG during an interview she understood the mother's reluctance to allow the Department to intervene in a family situation. The allegation was ultimately indicated against the aunt but unfounded against the mother, based on the investigator and supervisor's determination that the mother had given permission for the boy to be "whipped" but could not have anticipated that the corporal punishment would be so harsh. The other two reports were also unfounded, based solely on the mother's account of events. Although the investigator routinely communicated with the family's regular physician, he never shared any of the knowledge he possessed about Department involvement or issues in the home. The physician's minimization of possible abuse in the home, which was based largely on the mother's reports of the boy's self-injurious behavior, was then used by the investigator to support his conclusions.

After the sixth abuse allegation was made to the hotline, also detailing bruises and swelling to the boy's face, a second child protection investigator was assigned to the new report. The second investigator repeated many of the same errors of assumption and unquestioning acceptance made by the previous investigator, relying heavily upon his work and information provided by the mother. The child protection supervisor, who oversaw both workers, did not provide the second investigator with the case record of the indicated report against the aunt. The second investigator did not interview the mother until two months after the report was made because the mother's work schedule prohibited a meeting. When they did speak, the mother reiterated her standard responses, stating the boy repeatedly hurt himself and was often picked on at school, where she claimed the latest injuries had occurred. Despite learning the mother's boyfriend was living in the family home and that the boys frequently stayed with the brother's father, the investigator failed to conduct interviews with either man. The second investigator unfounded the report based on her belief the boy's supposed behavioral problems made him a likely target for bullies at school.

Nine months later, a seventh allegation was received by the hotline. The following day, before the Department had taken any measures to investigate the report, paramedics were called to the family's home where the boy was found dead in his bed. The death was ruled a homicide caused by blunt force trauma to the head resulting in a subdural hematoma. The medical examiner identified numerous scars, marks and other wounds at various stages of healing, including defensive injuries running from his left hand up to his shoulder. The medical examiner did not believe any of the boy's injuries were self-inflicted, determining them to be too extensive and severe.

Although an Unusual Incident Report (UIR) was completed following the murder, the Department currently has no internal mechanism in place to ensure the Post-Adoption Unit is notified of a child's death, instead relies upon information to be provided by adoptive parents. The mother did not inform the Unit and continued to receive adoption subsidy payments intended to support his care for 11 months after his death. The payments received during that time totaled over \$14,000. The payments were halted after the Unit was alerted of the boy's death and the mother relinquished her foster care license, however the Child and Youth

Centered Information System (CYCIS) did not reflect the license had been surrendered with cause. An OIG review of the mother's private agency licensing file found that while the agency had been aware of the repeated child protection allegations involving the family, staff was not aware of the details of the precipitating incidents and had not conducted required licensing investigations in every instance.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

- 1. This case will be referred to the State's Attorney's Office for review for possible charges of endangering the life of a child and to pursue recovery of \$14,036 that the mother collected after the boy's death.**

The Inspector General's Office has referred this report to the State's Attorney's Office for review. The State's Attorney's Office is still reviewing the case.

- 2. CYCIS should be updated to reflect the mother's foster care license was surrendered with cause.**

The system was updated to indicate the license was surrendered with cause. A hold has been placed on the home with the Department's Placement Clearance Desk.

- 3. The Department should develop an internal mechanism to notify the post-adoption payment unit upon the death of a minor adopted child.**

The Office of Information Technology Services will have the additions completed by January 2008.

- 4. The Department's Office of Field Audits, Division of Monitoring/Quality Assurance should review the organization that provided counseling services to the boy to determine if the deficient record keeping in this case is systemic or limited to the particular therapist.**

Quality Assurance will conduct the review of the agency's counseling services. After the review is completed, Field Audits will recoup funds, if appropriate. Quality Assurance and Service Intervention will develop systemic approaches to monitoring counseling services.

- 5. The Department should pursue disciplinary action against the first child protection investigator for:**

Failure to interview the cousin or cousin's caretaker in the third report in order to corroborate the explanation given for the injuries; Failure to interview the boy in the first report sequence; Failure to consider evidence from the indicated second report involving the aunt in the fourth investigation; Failure to provide the family's physician with the context of the injury in the first report and then asking for her opinion; Failure to recognize that cumulative injuries required further investigation into the supervision of the boy or monitoring through a referral for services; Failure to recognize that the mother's unwillingness to fully cooperate in the second report compromised the Department's ability to monitor the boy's safety.

The employee received a written reprimand.

- 6. The Department should pursue disciplinary action on the child protection supervisor for:**

Failure to provide the second child protection investigator with a printout of the second report investigation when assigning her to the fifth report investigation; Her lapse in judgment in second report in failing to consider that the adoptive mother's lack of cooperation meant that the Department's ability to monitor during the pending investigation was compromised; Her lapse in

judgment in allowing the boy to remain home with an uncooperative adoptive parent, who had given permission for the abuse, without monitoring.

The supervisor received a suspension.

7. The Department should pursue disciplinary action on the second child protection investigator for:

Accepting without verification the mother's claim that the injuries being investigated in the fifth report could have occurred at school; Failure to do a data check, which would have informed her of the second report; Failure to explore who was providing care for the boy, knowing that the adoptive mother worked so many hours that the second investigator was unable to reach her for two months; Failure to interview the adoptive mother's boyfriend and failure to interview the brother's biological father and extended family.

The employee received a written reprimand.

8. This report should be shared with the family's physician as an educational tool.

The Inspector General's Office shared a redacted copy of this report with the physician.

9. This report should be shared with the private agency that held the mother's foster care license as an educational tool.

The Inspector General's Office shared a redacted copy of this report with the private agency.

DEATH AND SERIOUS INJURY INVESTIGATION 2

ALLEGATION

A seven year-old boy was physically abused and neglected by his foster mother.

INVESTIGATION

The hotline was contacted after a licensed foster parent was arrested and charged with domestic battery of the boy. Local law enforcement found the boy in his bedroom wearing urine-soaked clothing and cleaning his room with Lysol. There was no bed in the room and another foster child in the home had scratches on her arm. A second hotline call was received five days later alleging that the boy slept on a bare floor with no covers because he wet the bed. The reporter also alleged the foster mother made the boy stay in his room for hours and had struck him with a board on his buttocks and legs, causing bruises.

The foster mother, who had been licensed for eight years, was monitored by one private agency for the first two years before she transferred her license to a second private agency. The foster mother had been indicated for physical abuse of another foster child four years prior to her arrest, but the boy, who resided with her at the time, had been allowed to stay in her home. Two other foster children, placed by the second private agency, were also allowed to remain in the home. Over the next two and a half years, the Department investigated six additional hotline calls against the foster mother. The boy had been placed in the home by the first private agency. As a result, case monitoring was split between the first agency that had placed the boy and licensed the home and the second agency that had placed the other foster children.

The first allegation against the foster mother was made after the then two-year old boy was injured, reportedly from a fall down a slide. The investigation was unfounded. The following year, the foster mother was investigated after a bite mark was found on the boy. This report was also unfounded. In addition to the hotline calls, the private agency was notified by professional staff servicing the foster home of fears that the boy was being mistreated and was frequently confined to his room. That same year, the foster mother separated from her live-in boyfriend of 10 years. At this time the foster mother was the sole caretaker for four foster children and her two biological children. Also, there was no reassessment of the home or the foster mother's license capacity after the foster mother's boyfriend moved out. Several months later, the hotline was notified when another foster child in the home reported that he had bruising on his upper arm from his foster mother grabbing him, taking him to his room and withholding dinner. The foster mother was indicated and the child who was the subject of the investigation was removed, but the other children were allowed to remain in the foster home.

After the indicated finding, the second private agency conducted a licensing investigation, which resulted in a Corrective Action Plan that required the foster parent not to use corporal punishment, to attend crisis intervention training, to contact the agency for assistance in enforcing discipline and report all instances of discipline monthly. However, the licensing agency never notified the second agency of the Corrective Action Plan. While the licensing investigation had been proceeding, the boy's caseworker was notified that he had a black eye and a caseworker at the second agency (the same agency as the licensing investigator) was notified that one of the other children in the home had missed 26% of her early intervention appointments. None of this information was ever shared with the licensing investigator.

Six months later, when the boy was nearly five, the hotline was called to report that he had a gash on his forehead and smelled of urine. The boy had reported that his foster mother hit him with a "big green gun" because he wouldn't stay in bed. The foster mother reported that the injury occurred because the boy was a "head-banger." The child was removed from the home pending the DCP investigation. However, the other two foster children and the two biological children remained in the home. The investigation was unfounded.

and the child returned to the foster home despite the fact that a temporary caretaker reported she had never observed head-banging behavior from the boy and school personnel affirmed that they had not observed other difficult behavior reported by the foster mother. The foster mother had provided the investigator with a document that purported to be a medical evaluation that described head-banging behavior of the child. On closer examination, however, the document was merely repeating information that had been reported by the foster mother. Soon after the child protection investigation was closed, the foster mother reported that one of the other foster children had bruised her shoulder and face. The foster mother's home was reassessed by the private agency that monitored her license, which noted that the foster mother had completed two modules of training on discipline and had reviewed a parenting training tape. A version of the particular parenting training tape had been discredited during an earlier OIG investigation in which its support for confining children was found to have contributed to the suffocation death of a child.

Later that same year, the hotline was contacted by an anonymous reporter who claimed that one of the other foster children had stated, "I go potty and I don't get my butt spanked." The report was referred for a licensing investigation, although a call several days earlier that the same child had a black eye was not shared with licensing or opened for investigation.

When the boy was five and a half, his caseworker called the hotline to report she believed he was being mistreated in the foster home; that he reported being spanked with a paddle, pushed down the stairs and not being fed. The investigation was unfounded after the boy denied the allegations and the investigator saw no signs of bruising. Six months later, the hotline received an anonymous complaint that the foster mother disciplined the children by having them stand in a corner with a dirty sock in their mouth and making them keep their hands in the air for 10 to 15 minutes. It was alleged the foster mother zipped the boy in a tent at night so he could not leave his room. The foster mother admitted she made the children stand in the corner, but only for short periods of time. She explained the tent as being necessary to discourage head-banging and the children all denied harm. The sixth child protection investigation was unfounded.

Just a few months later, the hotline was called after a school nurse observed bilateral bruising on the boy. The bruising was found to have been caused by a bee sting and the allegation was unfounded. When the boy was six and a half, the hotline was again called to report bruises on his forehead that the boy said were caused by the foster parent and that he may not have been receiving adequate food in the foster home. When interviewed, however, the boy claimed that the bruises were from banging his head on his bed. He denied that the foster mother had hit him. The foster mother told the investigator that the boy was a head banger and had a diagnosis of Reactive Attachment Disorder, which was used to explain why he would sometimes say bad things about his foster mother. The allegations were unfounded.

While the children were placed in the foster home, two of the children were referred for assessments. The assessing agency assessed each child in isolation, despite the fact that information from both children would have provided links to note the problematic context of the foster home itself. One of the caseworkers for the private agency that had placed the boy visited the home on several occasions. The caseworker focused on the boy's enuresis as being intentional and thought to affect the child's behavior by asking him if he liked the smell of urine.

One month later, the sheriff's department called to report having found the boy in urine-soaked clothing in a room without a bed, forced to clean his room with Lysol.

The OIG investigation found an almost complete lack of information sharing between the two private agencies monitoring the home. In addition, the notification system designed to ensure that licensing monitors and caseworkers were informed of child protection investigations also failed.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The assessment agency should incorporate the recommendations of American Academy of Child and Adolescent Psychiatry and the recommendations of the APSCA Task force into their assessment practices.

The Inspector General's Office shared a copy of the redacted report with the private agency.

2. This report should be shared with the assessment agency.

The Inspector General's Office shared a copy of the redacted report with the private agency.

3. Procedure 383, Licensing Enforcement must be revised to address the deficiencies in notification and completion of licensing investigations of licensed foster homes. In 2004, the Inspector General recommended and the Department agreed to have Quality Assurance conduct a review of Central Office of Licensure's method of identifying CANTS reports on licensed foster homes and establishing a schedule of reliability checks for the system of identifying foster homes with a CANTS report. (See OIG Report 03-1079, June 30, 2004, Recommendation # 5.)

Final revision of Rule 383 was submitted for approval. JCAR process has not been completed and the Director's office wants to review further.

4. Rule 383 has been in draft form for over a year. The Department should prioritize finalizing the promulgation of this important rule.

Final revision of Rule 383 was submitted for approval. Notice of Adoption of the rule will be filed when draft is approved.

5. Until a new Procedure is developed, the Department must immediately implement a protocol to ensure needed notification of Licensing and Child Protection investigations to all licensing and child service workers.

The OIG will work with A & I Licensing and the Office of Child and Family Policy to develop a notification protocol, which will include a notification tracking mechanism. It will be included in Rule 383. If Rule 383 is not ready for distribution after the protocol is developed, they will prepare a policy transmittal.

6. The Department's licensing standards should require a reassessment of a foster home license when the licensing agency becomes aware of a major change in the family composition, such as a spouse/paramour moving out of the home. The reassessment should include a review of the foster parent's capability to care for the children in light of the loss of a second caretaker as well as the circumstances surrounding the change and any ensuing custody or other legal disputes.

This reassessment is part of an existing standard.

7. The Department should evaluate and address private agencies' practice of splitting cases between agencies for licensing and child welfare placements.

The OIG is reviewing policy transmittal 2006.07 for possible changes in language.

OIG Response: The OIG submitted a detailed memorandum outlining specific recommendations to address

problems inherent in shared home responsibility cases. The document provided by the Department does not address those recommendations.

8. The second private agency's licensing staff should discontinue the use of the parenting videotape and incorporate scientific literature (such as Webster-Stratton and Patterson, Reid and Dishion) evidenced-based parent management training and interventions into their licensing corrective action plans for foster parents who demonstrate difficulties managing foster children.

The Inspector General's Office shared a copy of the redacted report with the private agency. The Inspector General met with agency Administrators and a member of the agency's Board of Directors to discuss the findings and recommendations in the report. The agency agreed to discontinue use of the videotape and replace it with relevant scientific literature.

9. This report should be shared and discussed with the first private agency's caseworker and the caseworker's supervisor. The caseworker and his supervisor should be disciplined for the caseworker's response to the boy urinating in his room. The caseworker questioning the boy if he liked the smell of urine, as documented in his July 7, 2005 Foster Home Visit contact sheet, was humiliating and punitive.

The Inspector General's Office shared a copy of the redacted report with the private agency. The Inspector General met with agency Administrators and a member of the agency's Board of Directors to discuss the findings and recommendations in the report. The caseworker and the supervisor were disciplined.

10. The first agency should train their caseworkers for specialized foster care in the above scientific literatures to educate them on the differences between positive and punishing interventions.

The Department agrees. The OIG provided the agency with the relevant literature.

DEATH AND SERIOUS INJURY INVESTIGATION 3

ALLEGATION

A four month-old girl died as a result of physical abuse inflicted by her aunt's boyfriend. Two child protection investigations into abuse of the infant were pending at the time of her death.

INVESTIGATION

The girl was born eight weeks premature to a 20 year-old mother with severe developmental delays. The two lived in a home along with the baby's grandmother, who was also developmentally delayed, grandfather, the baby's aunt, the aunt's boyfriend and the couple's one year-old daughter. The family came to the Department's attention following the baby's birth because of questions regarding the mother and grandmother's ability to serve as her primary caretakers. Following a child protection investigation, it was determined the aunt would assume responsibility for the baby and that the grandfather would assist when possible, although his work schedule meant his involvement would be limited. The case was unfounded and referred to a private agency for intact family services. During the course of the investigation, several community support professionals who worked with the family described verbally abusive outbursts and threatening behavior exhibited by the aunt's boyfriend towards them and stated the female members of the family had confided their fear of him. The mother and grandmother originally spoke of the boyfriend's aggressiveness and intimidation, but later recanted their stories. The baby's great aunt, who did not live in the home, also expressed concerns related to the boyfriend's gang activity and her belief domestic violence occurred in the household.

As intact family services were initiated, the assigned private agency caseworker prepared a service plan. The service plan did not specify who would serve as the baby's main caretaker and did not delineate what responsibilities the mother and grandmother could perform without supervision. The plan also did not contain a functional assessment of the mother to determine the degree of parenting she was capable of achieving. The plan was not signed by any family members. Although the professionals already involved with the family informed the caseworker of the boyfriend's volatile behavior and threats he had made against them and the baby, including hearing him say he would, "throw the fucking baby out the window," none of those conversations were recorded in the case notes. The caseworker did record that because the boyfriend, "failed to make himself available," he met him on only one occasion and did not find him to be belligerent. In separate interviews with the OIG, both the caseworker and his supervisor expressed their belief that the community support professionals were primarily responsible for providing services to the family. The caseworker told the OIG he had never been made aware of the boyfriend's intimidation of other professionals and threats against the baby. However, during an interview with police after the child died, the caseworker stated he had been informed of the incidents. The supervisor stated it was the belief of intact family services staff that the boyfriend was not a member of the household and that if she had been aware of his abusive behavior, she would have had the baby removed.

Two months after the intact family services case was opened, the State Central Register (SCR) received a report that the baby had a bruise on the side of her face. A child protection investigator was assigned to assess the allegation and began by interviewing the grandmother in the family home. The grandmother stated the baby's injury was the result of an accident that occurred when she squirmed as the mother was giving her a bath. The investigator accepted the grandmother's explanation and did not interview the mother or any other members of the household. In her interview with the OIG, the investigator cited the fact the grandmother had, "raised two children," as part of her rationale that she was an adequate caretaker, failing to recognize the baby's great-grandmother, who passed away before the girl was born, had been largely responsible for raising the mother and the aunt.

While the second investigation was pending, a third report of injuries to the baby made to SCR, alleging she

had fresh bruises running along the side of her face. The child protection investigator returned to the family home and spoke to the aunt and her boyfriend. The aunt attributed the bruises to the baby rolling over onto toys in her crib. The investigator accepted the aunt's account despite extensive research in the field demonstrating that children under the age of nine months rarely possess the ability to exert the force required to create bruises on themselves and that such injuries to infants under six months are "extremely rare." The boyfriend stated he had not been present when the injuries occurred. Although a Law Enforcement Agency Database System (LEADS) check showed the boyfriend had a criminal history consisting of 20 arrests, including six convictions for robbery, property damage and weapons charges, this information was not taken into account when assessing possible risk to the baby. In an interview with the OIG, the investigator's supervisor stated she had reviewed the criminal background information, but determined it was not a factor since he had had no serious charges leveled against him during the previous six months. In a separate interview, the investigator stated she was unaware of the boyfriend's criminal history.

Three days after the third abuse report was made to SCR, the baby was pronounced dead at a local hospital after being transported by paramedics from the family's home. During the ensuing police investigation, various family members reported witnessing the boyfriend regularly physically abusing the baby and described his jealousy whenever the aunt cared for the girl rather than their child. The boyfriend was subsequently arrested and charged with the girl's murder. His daughter was removed from the home and placed in the custody of a relative.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should discipline the child protection investigator for failing to assess risk and conduct adequate investigations of allegations of bruising to an infant.

The employee received a three-day suspension.

2. The Department should discipline the child protection supervisor for failing to ensure an adequate assessment of risk and ensure that thorough investigations were conducted.

The Department initiated discipline proceedings.

3. In accordance with agency personnel policy and procedures, the private agency should consider discipline for the intact family services worker for his lack of family assessment for intact services, minimizing signs of violence, intimidation, and possible exploitation in the home, and providing false information to the Inspector General's Office.

The Department agrees. The report was shared with the private agency. The Inspector General met with agency Administrators and a member of the agency's Board of Directors to discuss the findings and recommendations made in the report. The intact worker was disciplined.

4. In accordance with agency personnel policy and procedures, the private agency should provide discipline to the intact family services supervisor for her failure to recognize the boyfriend as a member of the household, for failing to ensure a realistic service plan was developed, and for failing to recognize signs of domestic violence in the home.

The supervisor was disciplined.

DEATH AND SERIOUS INJURY INVESTIGATION 4

ALLEGATION

A two and a half year-old girl died as a result of closed-head trauma consistent with being violently shaken. A Department investigation into physical abuse of the girl was unfounded eight months prior to her death. In addition, concerns regarding the Department's cooperation with local law enforcement were raised during the subsequent criminal investigation into the homicide.

INVESTIGATION

The initial child protection investigation into abuse of the girl was undertaken after the girl's mother and maternal grandmother brought the girl to a hospital emergency room with bruises to her head and face. Both women stated the injuries had occurred as the result of a fall while the girl was in the care of the mother's boyfriend and that they had not been present at the time. The girl's mother and father, who were estranged, later took the girl to see the family's primary physician who informed them he would report the injuries to the Department. Shortly after the doctor made his report, a mandated reporter also contacted the hotline. The second reporter stated that the child had a series of minor injuries the previous two months. The second reporter's account was accepted as related information to the doctor's report and an investigation was opened.

The doctor told the assigned child protection investigator that while he had never before had concerns regarding the girl's safety, he was unsure about the explanation provided for the girl's injuries and wished to err on the side of caution. When asked by the investigator whether he believed the parents had abused the girl, the doctor stated he was unsure and that it was the investigator's job to make that determination. The investigator responded that without confirmation from the doctor that the girl had been abused, there was little he could do. The doctor refused to assert the injuries were definitely the result of abuse. The investigator then interviewed the second reporter. The second reporter also said she could not say with certainty that the girl's injuries had been the result of abuse. The investigator told the second reporter that contacting the hotline so long after incidents had occurred was not useful and that the parents would simply deny the allegations.

The investigator later conducted a follow up interview with the doctor and told him that, based on interviews with the mother, maternal grandmother and the boyfriend and emergency room records, he had no reason to suspect abuse unless the doctor believed otherwise. The doctor again stated he could not positively state the girl had been abused and had no concerns about the parents but was unfamiliar with the boyfriend. The investigator did not inform the doctor of the second reporter's statement of other injuries to the girl that coincided with the mother and boyfriend's cohabitation. In an interview with the OIG, the investigator stated he had never been instructed to share such information. The investigator did not interview the girl's father at any point, even though he was a fixture in the child's life and regularly cared for her. The investigator stated he did not see any need to conduct such an interview. The investigator consulted with his supervisor and a decision was made to unfind the report for insufficient evidence. Eight months later, the girl was transported by ambulance to the same hospital emergency room unconscious and was pronounced dead after resuscitation efforts proved unsuccessful. A pathologist determined that the fatal brain injuries she had suffered had occurred no more than 18 to 24 hours prior to her death, during which time her only caretakers were her mother and her mother's boyfriend. The boyfriend has been charged with the murder and is awaiting trial.

On one occasion a paternal relative of the girl attempted to convey concerns for her safety to Department personnel. The relative arrived at a Department field office with what he believed to be evidence of possible abuse. Staff at the office instructed the relative to contact the State Central Register and provided him with the number, but did not meet with him to review the evidence or facilitate him making a call. Ultimately the relative left the office and did not communicate his concerns to the hotline.

Following the girl's death, investigators from the local sheriff's department subpoenaed Department records of the unfounded child abuse report. Department staff initially refused to comply with the request based on an interpretation of the requirements of the Abused and Neglected Child Reporting Act (ANCRA) by Department administrators and legal advisors. The Department later sought guidance from the State Attorney General's Office, which determined that the Act gave that office the authority to release a redacted copy of the unfounded investigation to the Assistant State's Attorney pursuant to the subpoena.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department Director should issue a clarification memo to the Child Protection Division that involved fathers must be interviewed in child protection investigations.

The clarification memo is being revised and will be distributed by December 2007.

2. The OIG reiterates its recommendations in OIG Report #060778, June 30, 2006 that:

(a) The Deputy Director of Child Protection should develop prompting questions that must be used in supervision of all investigations in which a physical injury is alleged. Use of this list should be required by Procedure 300 and be included in the investigative record. Questions should include, but not be limited to:

- Have there been a series of injuries to child(ren) in the home in the last 6 months
- Have there been any changes in household composition or caretaking that correspond with the onset of injury?
- If parents are separated or divorced, have both parents been contacted for information and/or placement?
- Has there been a delay in seeking care for any of the injuries?
- Were there any witnesses to the injury, if so, what did the witnesses report?
- Is the explanation for the injury consistent with the injury? Whose opinion is it and what facts were shared?;
- Were conflicting explanations given for the injury? What were they and by whom?;
- Are the injuries occurring only in one setting (e.g., home v. school or daycare)?;
- Are the injuries occurring only with one particular caretaker?
- Have the factors allegedly causing the injuries occurred across settings?;
- Was there corroboration for the explanations given for the injuries? What was it?.

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

(c) Once these components are developed, all child protection investigators, supervisors and managers should be trained on (a) and (b)

The questions have been incorporated into revised Procedures 300 and the Office of Child & Family Policy has forwarded the final draft to the Division of Child Protection. The P300 workgroup is reviewing the final

draft and will be completed by December 15, 2007.

3. Training referred to in (3) above should include what information can be shared with doctors so that concerns about violating confidentiality will not put children at risk.

The Department agrees.

4. Rule 431 should be amended to clarify that the Department can share unfounded investigative information during a subsequent child protection or criminal investigation with any persons named in Section 11.1 for purposes consistent with ANCRA or criminal prosecution.

DCFS Legal has assigned an attorney to draft amendments to ANCRA, which address the above issue, as well as other proposed changes to ANCRA, and will submit as a single legislative package. Targeted completion date: May 2008.

5. The Department's Legal Division should issue a clarification memo to Legal staff that unfounded reports can be shared with coroners, medical examiners, and State's Attorney's when relevant to a pending criminal or child abuse investigation.

The Department disagrees. In light of the fact that ANCRA is unclear about whether the records can be released, the safest course for purposes of liability is for DCFS Legal to review the individual request, and to seek advice from the Attorney General and direction from a court as required. Furthermore, the report does not indicate that the delay in seeking assistance and direction from the Attorney General's Office impacted the results in any way. DCFS Legal took the safest course in light of the contradictory nature of ANCRA.

6. The child protection investigator should be counseled concerning information sharing with doctors; critically analyzing information; and the potential that his interviewing technique had for discouraging witnesses from sharing full information.

The employee received counseling.

7. Department Procedures should be amended to include a provision that when someone walks into a Department office with a concern about child abuse or neglect, they should be invited into the office to make a hotline report or to talk to an investigative supervisor if they have questions or concerns about making the report.

The Office of Child and Family Policy has forwarded the final draft of P300 to the Division of Child Protection. The P300 workgroup is reviewing the final draft.

OIG Response: The final draft of Procedure 300 does not contain language that addresses this recommendation.

DEATH AND SERIOUS INJURY INVESTIGATION 5

ALLEGATION

A two year-old boy died as a result of multiple internal injuries caused by physical abuse. A child protection investigation of burns and other injuries the boy had previously suffered was unfounded three months prior to his death.

INVESTIGATION

The first abuse investigation was initiated after the boy was brought to a hospital emergency room by his father and paternal grandmother after they observed several injuries, including burns to his head and hands, during a visit. The boy's mother told hospital personnel that her son had knocked over a lamp and burned himself on the bulb. The mother stated her boyfriend had been watching the boy and the couple's three month-old daughter at the time and she was not in the home when the incident occurred. The boyfriend corroborated the mother's account and said he had been sleeping when he was awakened by the boy's cries. While in the emergency room, the boyfriend became disruptive and combative, at one point swinging the three month-old around in her baby carrier. Hospital security called police and the boyfriend was arrested for disorderly conduct and removed from the premises.

Following the arrest, the child protection investigator assigned to the case arrived at the hospital and conducted a joint interview of the mother along with a police officer. The mother reiterated her story and stated that her boyfriend's mother had taken the two year-old home with her after he suffered the injury because she, "was not sure what was going on and was fearful that someone was not treating [the boy] right." It was not until the next day after the boy had returned home that his father and maternal grandmother took him to the hospital. The mother told the investigator and the officer she had not sought medical treatment for her son sooner because she feared Department involvement. The investigator examined the boy and noted several bruises and marks of various ages, including one to his forehead, in addition to the burns.

Throughout his handling of the case, the investigator's efforts to ascertain the facts of the incident fell short of the standard established by the Department. The investigator did not conduct a scene reenactment of how injuries to the boy were alleged to have occurred, despite being instructed to do so by his supervisor. He failed to recognize inconsistencies in the explanations provided for how the boy was hurt and did not seek a medical consult about their plausibility, even though skepticism had been voiced by a treating physician. The investigator did not consider the totality of the injuries the boy suffered or review medical records to ensure he was aware of their extent. The investigator also neglected to make required collateral contacts or notify the Child Advocacy Center to alert them the boy had suffered a serious injury. The investigator ultimately unfounded the report, a decision approved by his supervisor, based on the rationale that the injury that prompted the allegation to be made had been satisfactorily explained. The OIG recognized that investigators in the local field office had caseloads above the optimal limit established by the Department.

Three months after the report was unfounded, paramedics were called to the mother's home after the boy was found unresponsive in his bed. Paramedic's efforts at resuscitation were unsuccessful and he was pronounced dead at a local hospital. An autopsy found cerebral edema, subdural hematoma and retinal hemorrhages consistent with an impact injury as well as contusions and a lacerated liver. Numerous injuries at various stages of healing were identified including an area of congealed blood inside the skull, suggesting the presence of an older hematoma. The death was ruled a homicide. A criminal investigation into the death is still pending. The unfounded child protection investigation into the initial abuse of the boy was expunged while the second investigation into his death was still pending, limiting the ability of those investigating the death to access previously available information.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

- 1. The child protection investigator should be disciplined for his failure to critically investigate this case, tempered by the fact that his caseload was above B.H. limits.**

The employee received an oral reprimand.

2. The child protection supervisor should be disciplined for his failure to supervise the investigator and ensure he critically investigated this case.

The supervisor received a written reprimand.

3. Child protection management should immediately review caseloads at the field office to determine if the problems with B.H. limits have been remedied.

The review of caseloads was initiated immediately upon completion of re-alignment. It is ongoing. With rare exceptions the CPIs are at or below BH. The field office reported doubling the number of CPIs as a result of re-alignment.

4. The Department should ensure that child protection investigations, both unfounded and indicated, are not expunged while a subsequent investigation, involving the same family, is pending.

The Department is considering whether to pursue a change in legislation to implement this recommendation.

5. Department Procedure 300.70, "Referrals to the local law enforcement agency and State's Attorney" should be amended to include second-degree burns as injuries requiring referral to local law enforcement and the state's attorney.

Language regarding this recommendation is being drafted and will be submitted to the Office of Child & Family Policy for approval.

6. This report should be shared with the State's Attorney currently involved in reexamining this case.

The Inspector General's Office shared a copy of the redacted report with the State's Attorney.

DEATH AND SERIOUS INJURY INVESTIGATION 6

ALLEGATION

An 11 year-old girl with diabetes died of cardiac arrest. Two child protection investigations of medical neglect of the girl were closed two months prior to her death.

INVESTIGATION

The family became involved with the Department three years earlier when hospital staff contacted the hotline alleging medical neglect by the child's mother. The girl had not been receiving her insulin shots, which resulted in two hospitalizations for hyperglycemia within the same month. The child protection investigator assigned to the report found that both the girl's aunt, who sometimes cared for her, and the mother had been inconsistent in administering her insulin shots. Prior to closing the case, the child protection investigator was informed by hospital staff that the mother appeared to be making a more concerted effort to ensure the girl received her shots. The mother was indicated for medical neglect and the case was opened for intact family services.

According to the intact worker's contact notes, the worker conducted weekly visits with the family for a period of one year without documenting any major concerns or events. However, OIG investigators discovered the same language repeated verbatim throughout the case file. The intact file also contained a blank consent for release of information that had been signed by the mother. According to medical records, the girl had not been seen at the diabetes clinic nor had the diabetes log been updated since the intact family case was opened. The intact worker, without verifying information or monitoring medical appointments, rated the service plan as "objective achieved." The intact worker failed to utilize the school as a resource for information and was unaware the school nurse had difficulty getting the girl's mother to cooperate with a diabetic care plan or that the girl had missed 21 days of school.

Two months prior to closing of the intact case, the child was hospitalized for nine days for hyperglycemia, at which point the hospital again contacted the hotline and a second investigation was initiated. In an interview with the OIG, the intact worker stated she did not know that the girl had been hospitalized, that a second investigation had been opened or that the hospital had arranged for a visiting nurse to go to the family's home once a day for a month to monitor the girl's diabetes. The second child protection investigator failed to review the prior investigation or contact the previous child protection investigator. By failing to complete a data check, the second child protection investigator did not know about the open intact case. The girl's mother was again indicated for medical neglect. The second investigator told the OIG that the case was then referred for intact family services, however a second intact case was never opened.

Two years later, school personnel contacted the hotline to report that the child's mother had failed to provide the school with necessary supplies to manage the girl's diabetes and that the school had difficulty reaching the mother when the girl's insulin levels were too high or low. A third child protection investigator was assigned to the report and went to the family's home but was unable to gain entry. Six days later, the third investigator went to the girl's school, where the nurse provided a chart displaying the girl's high blood glucose levels. When the investigator met with the girl, the girl showed the investigator her glucose meter which displayed a level of 389 mg/dl and a previous level of 539 mg/dl. The girl told the investigator that a normal level for blood glucose was between 80-120 mg/dl. The third investigator took no action and the girl was hospitalized later this same day to stabilize her blood glucose level. It was not until a month later that the third investigator made another attempt to visit the family's home, however no one answered the door.

While the third investigation was still pending, the hotline received a call from a school nurse from a different school. The nurse reported that the family had recently moved to the area and the girl had transferred schools. The nurse also reported that when she contacted the girl's mother because the girl's glucose levels were over 400 mg/dl, causing her to experience nausea and blurred vision, the mother told the nurse that, "she wasn't

taking her daughter to the hospital and she would take care of it.” The nurse also reported a significant period of time had passed since the girl had been to a doctor and had missed recent medical appointments. The third investigator assumed responsibility for the new report. When the third investigator met with the girl’s mother, the mother could not provide a description of what a balanced meal for the girl consisted of and stated that when the girl’s glucose levels were high she would give her water to bring the levels down.

The girl’s mother agreed to give the aunt private guardianship of the girl. The mother was informed that both pending investigations would be indicated for medical neglect. The third investigator told OIG investigators that she did not review the prior investigations or medical records documenting concerns regarding the aunt’s ability to care for the child. The third investigator stated that the plan was for the girl to reside with the aunt and that the aunt would pursue private guardianship. The investigator said she faxed a referral to the extended family support program in order to assist the family with the private guardianship process. However the fax was sent to a defunct agency and the family never pursued private guardianship.

Two months after the third and fourth child protection investigations were closed, hospital personnel contacted the hotline to report the girl’s death. Allegations of medical neglect and death by neglect were made against both the mother and the aunt. The treating physician reported that when the girl’s mother and aunt brought the child to the hospital the child was in cardiac arrest, malnourished, dehydrated and had a staph infection. Doctors reported that the girl’s immune system was weakened as a result of her untreated diabetes, preventing her body from resisting the staph infection.

The mother was indicated for medical neglect but the death by neglect allegation was unfounded. The allegations against the aunt were unfounded. In an interview with the OIG, the child protection supervisor stated the death by neglect allegation had been unfounded because the hospital did not call the hotline until 16 days after the girl’s death and had offered the family the option of having an autopsy performed, but they declined. The supervisor reported that when hospital staff believe a family is at fault they require an autopsy, but in this case they did not and hospital personnel could not say that the child died as a result of negligence on the part of the family.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The intact family services worker should receive discipline for her failure to monitor whether the child’s medical needs were being addressed.

The Inspector General’s Office shared a copy of the redacted report with the private agency for consideration of discipline.

2. The agency should provide training to staff to prohibit seeking signatures on blank consents for release of information.

The Inspector General’s Office shared a copy of the redacted report with the private agency.

3. The second child protection investigator should be disciplined for her failure to complete a data check, review the prior child protection investigation or obtain relevant medical records.

The Department has begun discipline proceedings.

4. The third child protection investigator should be disciplined for her failure to: respond to the girl’s immediate health crisis, obtain relevant medical records and review prior child protection investigations as required by Procedures 300: Appendix B, and her lack of diligence in locating the family.

The Department has begun discipline proceedings.

5. Department procedures should be amended to require that in child protection investigations in which the plan is for a family member to obtain private guardianship of the child/ren, the family should be referred to the Extended Family Support Program for assistance in obtaining private guardianship.

The draft protocol was reviewed by the DCP Deputy Director and recommendations for changes were submitted to the workgroup. The workgroup is currently reviewing the revisions. Target completion date: December 1, 2007.

DEATH AND SERIOUS INJURY INVESTIGATION 7

ALLEGATION

A three week-old girl died of asphyxiation after being accidentally smothered by her sleeping mother. A child protection investigation related to the mother's mental health issues and prior involvement with the Department was pending at the time of the baby's death.

INVESTIGATION

Two years prior to the baby's death, the mother had been the subject of an indicated report after being observed by a police officer disoriented and wandering the streets while carrying her naked then one year-old daughter. Following this episode the mother was admitted to a psychiatric hospital. Ten days after she was released, while the subsequent child protection investigation was pending, the hotline received a call reporting the mother had brandished a knife towards her sister and the baby's grandmother and threatened to kill them. The grandmother stated the mother had been non-compliant with her medication schedule and had been abusing alcohol and illegal substances. Responding to the report, the assigned investigator encountered the mother and her child at the home of a friend. The investigator determined the mother's continued erratic behavior to be a threat to the child and took the girl into protective custody.

A service plan was developed for the mother while her child was placed in foster care, however the mother consistently failed to fulfill her obligations to the program or participate in required activities. The mother was frequently hostile in her dealings with child welfare professionals from the private agency handling her case and did not regularly take the medicine prescribed for her diagnosed schizophrenia. After it was learned the mother had become pregnant, pre-natal care was added to her service plan. However, the mother continued to exhibit ambivalence towards services and refused to make herself available to workers or provide them with her current address or contact information. After the mother persisted in harassing and threatening the grandmother, who continued to care for the child, the grandmother obtained a restraining order against the mother with the assistance of involved workers. After a sustained period of non-compliance, the mother began tenuous involvement with services, during which time she acknowledged continuing to use drugs during her pregnancy and neglecting to participate in pre-natal care. Following the baby's birth, private agency staff failed to contact the hotline to document the presence of a new child in the mother's home. In an interview with the OIG, the private agency caseworker stated she believed agency staff had called the hotline upon the baby's birth, however a review of the case file and the State Automated Child Welfare Information System (SACWIS) found no record of any contact being made.

Three weeks after the baby was born, the caseworker called the hotline to report the mother was delusional, exhibiting stress and neglecting to take her medication. The call was accepted and a child protection investigator was assigned to the case. In executing his duties, the child protection investigator made minimal effort and failed to utilize available information regarding the mother's history of combative behavior and medical non-compliance. The investigator completed a Child Endangerment Risk Assessment Protocol (CERAP) that determined the baby to be safe without noting risk factors such as the mother having a child previously removed from her care or her pronounced mental health issues. In an interview with the OIG, the investigator stated he had not reviewed any of the mother's historical mental health information but relied upon his evaluation of her during their meeting, citing his past work in a psychiatric ward to support his judgment. The investigator also did not request a professional assessment of the mother because he assumed the mother was making progress based on his understanding she was compliant with services. The investigator stated that mental illness, poverty or drug use were a factor in all of his cases and presumed the report would ultimately be unfounded as it was a "generic" allegation made in response to the baby's birth. The investigator did not complete a Home Safety Checklist, which would have required him to ensure the mother understood the importance of not sleeping with her newborn daughter and recognized the increased risk of rollover death when parents use drugs or alcohol. The investigator said he was unfamiliar with use of the Home Safety Checklist and was unaware the mother had substance abuse issues. The child protection investigation was still pending at the time of the baby's death.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

- 1. In child protection investigations involving an open Department case, the child protection investigator should arrange for an in-person joint interview of the caseworker and supervisor of the open case to obtain information pertinent to the child protection investigation.**

There is already a process in place. However, it will also be part of the safety model.

- 2. The child protection investigator's supervisor should use this report to counsel the investigator on: a) his failure to consider the significance of the previous indicated report and that the grandmother had obtained an Order of Protection against the mother; b) his bias for accepting the direct report of the parent; and c) his failure to corroborate information with key mental health collaterals and failure to obtain relevant mental health documents.**

The employee received counseling.

- 3. The child protection investigator's supervisor should closely monitor the investigator's investigations involving mental health issues over the next 12 months to ensure that the above errors are not repeated.**

The investigator is being closely monitored.

- 4. The child protection investigator should receive remedial training from a Department clinical psychologist on interpreting psychological evaluations.**

The Department's Clinical consulting psychologists provided a training session to Child Protection, Operations and POS agency staff on the interpretation of psychological evaluation findings and recommendations. Fifty-one staff attended-15 from Child Protection, 28 from Operations and 8 from POS agencies, including this employee.

- 5. The appropriate Regional Administrator or their designee and the Chair of the local Death Review Team should meet with the Executive Director of the County Mental Health Board, to develop a system of timely retrieval of mental health records and efficient sharing of information, including interviews conducted by the mental health professionals, during a child protection investigation.**

The Inspector General's Office shared a redacted copy of this report.

- 6. This report should be shared with the private agency to address the agency's failure to sufficiently plan for the birth of the mother's baby and critically assess the safety concerns present to the baby.**

The Inspector General's Office shared a redacted copy of this report with the private agency.

- 7. When a child welfare worker has a pregnant mother on his/her caseload who has been previously indicated for abuse or neglect and refuses to give the child welfare worker information as to the due date and expected place of delivery and the worker has concerns about the new baby, the worker should increase visitation within 2 months around the anticipated due date, document attempts to get consent to speak with doctors, document contacts with family and support network to seek notification of birth.**

Procedure is currently being revised. Targeted completion date: June 2008.

DEATH AND SERIOUS INJURY INVESTIGATION 8

ALLEGATION

A two year-old boy died of internal injuries resulting from physical abuse. An intact services case involving the boy's family was closed three months prior to his death.

INVESTIGATION

The boy's mother was a former ward who had been involved with the Department since the age of 11 and spent years moving between various relative and non-relative foster homes as well as residential placements. When she was 13, a psychological evaluation measured her IQ as being in the mildly mentally retarded range and at 15 she was diagnosed with intermittent explosive disorder, organic mood disorder and depression. In addition, the mother suffered from epilepsy and a related seizure disorder, a condition that also affected both of her children. A child protection investigation was initiated after the mother arrived at a hospital with her two children complaining of miscellaneous ailments. The family was homeless and the girl was not attending school. The family was eventually referred for intact services through the Department.

Throughout the time the family was involved in services, various workers expressed concerns the mother had developmental delays, however a functional assessment of her parenting ability was never conducted, particularly in regards to her management of her daughter's medical condition. Both mother and daughter required diligent monitoring of their epilepsy and regular compliance with their medicinal regimen. The mother's inability to comply with a regular schedule for administering their drugs was mistakenly attributed to an assumed lack of education and her shortcomings were excused on account of her demonstrated emotional commitment to her children. When it was learned the mother had been prohibited from receiving Social Security Insurance (SSI) benefits as a result of fraud perpetrated in her name by a relative, she was instructed to attend to the matter with SSI administrators but was not offered adequate assistance to navigate the bureaucratic procedures necessary to obtain funds for her and her children. Throughout the time the family's case was open with the Department, the mother was expected to perform tasks that exceeded her ability to function independently.

Because of the recurring problems faced by the mother, her ability to work towards stability was greatly compromised. Involved workers did not take a comprehensive approach to addressing the overall problems of poverty, homelessness, physical infirmity and developmental disability that presented obstacles for the family but instead focused on individual events as they arose as if they were isolated incidents. Department Best Practices require that when working with parents suspected of having developmental delays, it is imperative to secure an adaptive functioning assessment in order to provide staff with direction for case planning and ensure effective referrals for services. However, the Department does not currently provide staff with training on how to identify signifiers of possible developmental delays or the impact such limitations can have on parenting abilities.

Three months after Department involvement with the family ended, paramedics were called to the home of the boy's father, who had only learned of his paternity at approximately the time the intact services case was closed. The boy was pronounced dead at the scene and police opened a criminal investigation based on evidence of physical abuse. The father was subsequently arrested and charged with murder. He is currently awaiting trial. The family's case was reopened for intact services, however the same problems that hampered the previous involvement with the Department persisted. The mother was the subject of allegations of medical neglect for failing to consistently comply with her daughter's medical schedule but the report was later unfounded. As physicians continued to struggle to control the mother's seizure disorder, they decided to place the mother in a medically induced coma. The daughter, who was hospitalized at the same time as her mother, was briefly released into the care of relatives but was readmitted to the hospital after suffering seizures while in their home. No viable alternative caretakers have been identified for the girl and no contingency plan for her long-term welfare has been established.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should amend Procedures 302.388 Intact Family Services to provide that parents with developmental disabilities are referred to community resources that

specialize in working with the developmentally delayed population for community linkage and additional case management services.

The revisions to 302.388 have been requested.

2. The Department should amend Procedures 302.388 Intact Family Services to provide that children and parents with epilepsy are referred to the Epilepsy Foundation for education, case management and assistive resources.

The revisions to 302.388 have been requested.

3. The Department's Division of Clinical Practice should develop training and resources for working with caregivers with developmental disabilities to be included in the Department's core training curriculum.

The content of the training is developed and will be converted into web-based training. It will be included in the pre-service training for all job specialties and caregivers.

4. The Department's Division of Clinical Practice should assist child protection and case management staff in managing cases involving caregivers with a developmental disability.

The content of the training is developed and will be converted into web-based training. It will be included in the pre-service training for all job specialties and caregivers. Anticipate completion date: December 2007.

5. The Department should train Child Protection and Intact Family staff on utilization of the Social Security Administration's consent for release of information to obtain information on a parent or child's qualifying disability.

This is included in the on-line orientation training. Confidentiality and release of information is currently covered in training for all staff and will be included in the revised Foundations, which will be ready for delivery in December 2007.

OIG Response: The orientation training does not include training on securing consent to access relevant social security disability information.

6. The Department should amend Procedures 302.388 Intact Family Services to provide that when a parent has a condition that may become debilitating, Intact Family staff ensure that the parent has a back-up caregiver plan that meets the child's medical, developmental and scholastic needs.

The revisions to 302.388 have been requested.

7. The Department's Intact family services should assist the mother with a referral to a community agency for family group conference services with the mother and extended family to explore sources of support including housing options and designation of a payee once the mother's SSI benefits are approved to avoid exploitation.

All referrals for additional support services and obtaining adult guardianship were initiated.

DEATH AND SERIOUS INJURY INVESTIGATION 9

ALLEGATION

A four month-old infant was found dead. At the time of the baby's death, the infant and a one year-old sibling were wards of the Department.

INVESTIGATION

The infant was the fifth of six children born to his twenty-two year-old mother. An OIG review of the family's previous involvement with the Department found an extensive history of abuse and neglect allegations against the mother. Her oldest child had been removed from her custody and placed with his maternal grandmother who obtained legal guardianship of him through the probate court. The next two oldest children entered foster care as a result of the mother's chronic substance abuse and were later adopted.

Upon the birth of the infant, both the mother and the baby tested positive for illicit substances. The baby and his one year-old sister were removed from the mother's custody and taken into foster care. The children were placed in the maternal grandmother's home until she asked that they be removed and placed with paternal relatives after she determined she was unable to manage the care of two additional young children. Involved child welfare professionals worked to fulfill the request and a Juvenile Court Judge awarded guardianship of the siblings to the Department, at which time they were placed with paternal relatives.

One month later the children were moved to a traditional foster care placement one month later after it was discovered that their placement did not constitute a "relative" placement under Department Rules. Prior to their placement in traditional care, the Department caseworker informed the maternal grandmother of the situation and offered her the option of having the children placed back in her home.

Four days after the children were placed in the non-relative home, the maternal grandmother filed a Petition for Appointment of Guardian of the Person of the Minors in Probate Court. In her petition, the grandmother indicated that it was necessary that a guardian be appointed for the minors because, "*Children Family Services has custody. Parents (sic) are unable to care for the children.*" There was no indication that the Department was notified of the proceedings. Five days later, a Probate Court Judge granted the maternal grandmother private guardianship of the siblings. The maternal grandmother provided the Department with the Probate Court order and the children were returned to her care. Department staff planned to close the case because they incorrectly believed that a legal relationship with the Department no longer existed and that the maternal grandmother did not need services.

The conflicting orders (the juvenile court order granting guardianship to the Department and the probate court order granting guardianship to the maternal grandmother) were in effect for over a month until a Probate Court Judge vacated the order appointing the maternal grandmother guardian, recognizing the Department already had guardianship of the children. However, the children remained in maternal grandmother's physical custody because no one from the Department was aware of the probate court order vacating the maternal grandmother's guardianship. In an interview with the OIG, the maternal grandmother denied she was ever notified that she no longer had guardianship of the children.

In September 2006 the children's 19 year-old cousin, who was caring for the infant at the time, found him unresponsive. The cousin reported that she went to check on the infant and found him purple and not breathing. She also reported that after the Probate Court Judge awarded guardianship of the children to the maternal grandmother for the second time in the middle of June, the grandmother dropped the infant off at the cousin's residence and had not been back to see him since.

While more than one person involved with this case suggested that the maternal grandmother underhandedly

went to probate court and that the Department was acting in collusion to trick the court, the OIG investigation did not substantiate these allegations. However, prior to the OIG investigation, labor relations proceeded with discipline charges against the caseworker and her supervisor for negligent performance of duties, specifically for failing to take action to inform the Juvenile Court Judge, or Department administration, that the Probate Court's order violated a previous Juvenile Court order that granted temporary custody of the two children to the Department.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Director of the Department should send a letter to each of the circuit clerks (excluding Cook County) requesting that a clerk check for their court involvement (e.g. open juvenile court case) prior to a proceeding for guardianship of a minor.

The Director approved the Inspector General's draft letter to the circuit clerks.

2. A redacted copy of this report should be shared with the Acting Chief Judge in the appropriate county to alert him of the conflicting orders that were entered in this case and to determine if a system should be in place to notify all persons that were likely affected by a vacated order.

The Department agrees. The Inspector General's Office provided the Director a draft copy of the letter being sent to the Judge.

3. The anticipated training for graduated sanctions for child welfare workers should include more detailed court training (how to testify, how to screen, overlapping court involvement, court orders).

The Department agrees. The Office of Training will work with DPO to develop a more detailed court training curriculum. The training will be delivered beginning November 2008 to DCFS and POS child welfare workers.

DEATH AND SERIOUS INJURY INVESTIGATION 10

ALLEGATION

A six year-old girl with muscular dystrophy died of natural causes. Her family had an open case with the Department for intact family services at the time of the girl's death.

INVESTIGATION

The family had an extensive history of involvement with the Department stemming from issues related to poverty, substance abuse and a limited support structure. Contact was initiated following multiple reports of inadequate supervision of the parents' other four children, all of whom were under the age of six. Intact family services were provided in an attempt to assist the family in establishing stability, however the parents' compliance was inconsistent and frequently presented obstacles to worker's efforts to deliver necessary services. During the 13 months intact services were provided to the family, the parents were the subjects of eight child abuse and neglect investigations, three of which were indicated.

The serious medical complexities presented by the six year-old girl posed another significant challenge to the parents' ability to manage their family. Their lack of financial and interpersonal resources prohibited them from complying with all the girl's medical requirements. The girl's death further exacerbated the parents' negative behavior. Although homemaker services were provided, the parents' uneven behavior persisted and hampered attempts to ensure the children's needs were met. Involved worker's observed recurring problems in the home related to the provision of basic services such as heat and electricity in the home. Worker's also recognized the mother's cycles into and out of compliance with services which, in light of her known substance abuse issues and previous positive drug tests as well as the father's incarceration on drug charges, should have been critically evaluated. After the couple's youngest child was born prematurely and tested positive for an anti-depressant the mother had not been prescribed, the child protection investigator assigned to the report completed a substance abuse screen. The mother admitted to the investigator having used illegal substances during her pregnancy. Although Department procedure requires such cases to be referred for substance abuse assessment, no referral was made. The investigator's supervisor signed off on the screening without the referral having been conducted. In an interview with the OIG, the investigator was unable to provide an explanation as to why the referral was not made.

After more than a year of unsatisfactory participation in intact family services, the couple's four children were removed from their custody and placed in foster care. Three months later the youngest child was returned while the older child also subsequently returned home under Department guardianship. Although the family's compliance with services initially exceeded previous levels, patterns of behavior emerged, including the children missing appointments for daycare and being absent from school. As the Department retains guardianship of the children, it has the fiduciary responsibility to ensure the progress the children made while in foster care is maintained.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

- 1. The private agency monitoring the children's early intervention services should ensure their enrollment and attendance at Head Start and early intervention**

Programs. The children's education objectives should be incorporated into the family service plan.

All associated cases were closed by the private agency in January 2007 subsequent to the court order discharging the Department as guardian of these children.

- 2. To facilitate the parent's participation in their children's educational development, the two youngest children should attend protective day care one day a week to allow the mother to participate in the Head Start program and volunteer at her daughter's kindergarten class. The mother's participation in**

the children's educational activities should be incorporated into the family service plan.

All associated cases were closed by the private agency in January 2007 subsequent to the court order discharging the Department as guardian of these children.

3. The Department should request that the counseling center working with the father incorporate family therapy sessions into his treatment to help this young couple support each other in the recovery process and to assist them in their parenting and household management roles. The center should be respectful of the father's work schedule and protective daycare should be arranged so the parents can attend family therapy.

All associated cases were closed by the private agency in January 2007 subsequent to the court order discharging the Department as guardian of these children.

4. The child protection investigator should be counseled for not following Procedure 302: Appendix A-Substance Affected Family Procedure and his failure to include critical information in the Adult Substance Abuse Screen.

The employee was counseled.

5. The child protection investigator's supervisor should be counseled for failing to critically review the investigator's Substance Abuse Screen and lack of referral.

The employee was counseled.

CHILD DEATH REPORT

The Office of the Inspector General (OIG) investigates the deaths of Illinois children whose families were involved in the child welfare system within the preceding twelve months. The OIG receives notification from the Illinois State Central Register (SCR) when a child dies, when the death is reported to SCR.¹ The OIG investigates the Department's involvement with the deceased and his or her family when (1) the child was a ward of DCFS; (2) the family is the subject of an open investigation or service case at the time of the child's death; or (3) the family was the subject of an investigation or service case within the preceding twelve months. If the OIG learns of a child death meeting this criteria, that was not reported to SCR, the office will still investigate the death.

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

The majority of the cases are investigatory reviews of records, often including medical, police and school records in addition to records generated by the Department. While each case, individually, may not rise to the level of necessitating a full investigation and separate report, together they often indicate systemic patterns or problems that require attention. For example, several cases reviewed this year involved substance-abusing mothers with intact family cases who delayed assessment or entering substance abuse treatment, coming up with seemingly valid excuses, such as a sick child or lack of transportation. Workers allowed the situation to go on for months, unsure of what to do. The recently passed graduated sanctions legislation will enable workers to seek court orders requiring parents to comply with the treatment plan. The OIG will be working with the Department to train workers on how to use this new tool.

The Inspector General's Office continues to address systemic issues through a variety of means, including cluster reports, initiatives, and trainings. These reports, initiatives, and trainings have addressed substance abuse, infant sleep safety, and home safety. Current projects include developing evidence-based practice protocols and trainings to improve services to substance-affected and mentally ill parents, creating error reduction implementation plans (please see page 133 for more information), and reporting on minors reaching adulthood who require legal guardians.

In Fiscal Year 2007 the OIG investigated **111** child deaths, an increase from 86 deaths in FY 2006, although still lower than in the three years prior. A description of each child's death and DCFS

¹ SCR relies on coroners, hospitals and law enforcement in Illinois to report child deaths, even when the deaths are not suspicious for abuse or neglect. The deaths are not always reported. Therefore, true statistical analysis of child deaths in Illinois is difficult because the total number of children that die in Illinois each year is unknown. The Illinois Child Death Review Teams have requested that individual county registrars forward child death certificates to SCR to compile a list of all the children who die in Illinois. It is not known whether this is regularly occurring; in addition, some death certificates are sent to the Child Death Review Team Coordinator well after the fiscal year in which the death occurred. The Cook County Medical Examiner's policy is to report the deaths of all children autopsied at the Medical Examiner's office. The OIG acknowledges all the county coroners and Sharon O'Connor at the Cook County Medical Examiner's Office for responding to our requests for autopsy reports.

involvement is included in the annual report for the fiscal year in which the child died. This year's annual report includes summary information for children who died between July 1, 2006 and June 30, 2007. During this fiscal year, preliminary investigations were conducted in 7 cases; investigatory reviews of records were conducted in 76 cases; full investigations were conducted in 6 cases, with 5 reports to the Director; and full investigations are pending in 22 cases. Summaries of death investigations reported to the Director in Fiscal Year 2007 are included in the Investigations section of this annual report.

Summary

Following is a statistical summary of the 111 child deaths investigated by the OIG in FY 07, as well as summaries of the individual cases. The first part of the summary presents child deaths by age and manner of death, case status and manner of death, county and manner of death, and substance exposure status and manner of death. The second part presents a summary of deaths classified in five manners: homicide, suicide, undetermined, accident, and natural.²

Following this year's individual descriptions is summary data for the last 8 years of child death investigations (please see page 90).

Key for Case Status at the time of OIG investigation:

- Ward Deceased was a ward
- Unfounded DCP Family had an unfounded DCP investigation within a year of child's death
- Pending DCP Family was involved in a pending DCP investigation at time of child's death
- Indicated DCP Family had an indicated DCP investigation within a year of child's death
- Child of Ward Deceased was a ward's child, but not a ward themselves
- Open/Closed Intact Family had an open intact family case at time of child's death / or within a year of child's death
- Open Placement Deceased, who never went home from hospital, had sibling(s) in foster care
- Split Custody Deceased, who was at home with family, had sibling(s) in foster care (or out of home pursuant to a DCFS safety plan)
- Preventive Services Intact family case was opened to assist family, but not as a result of an indicated DCP investigation
- Return Home Deceased or sibling(s) was returned home to parent(s) from foster care within a year of child's death
- Extended Family Support Service case was opened to assist extended family members caring for children because of a child welfare need or safety plan
- Child Welfare Services Referral A request was made for DCFS to provide services, but no abuse or neglect was alleged

² The causes and manners of death are determined by hospitals, medical examiners, coroners and coroners' juries.

Table 1: CHILD DEATHS BY AGE AND MANNER OF DEATH

Child Age		Homicide	Suicide	Undetermined	Accident	Natural	Total
MONTHS OF AGE	At birth	2				3	5
	0 to 3	3		7	8	14	32
	4 to 6			3	4	3	10
	7 to 11					2	2
	12 to 24	1			2	4	7
YEAR OF AGE	2	2			3	3	8
	3	2		1		2	5
	4				2		2
	5				3		3
	6				1	2	3
	7	1					1
	8	1			1		2
	9				1		1
	10					1	1
	11	1				2	3
	12	1		1			2
	13	1				2	3
	14				2	1	3
	15	2	1	1		1	5
	16	2			2	1	5
	17				1		1
	18 or older	1			3	3	7
TOTAL		20	1	13	33	44	111

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

Reason For OIG Investigation*		Homicide	Suicide	Undetermined	Accident	Natural	Total
DCP	Pending	4		2	2	7	15
	Unfounded	5	1	4	16	10	36
	Indicated				4	2	6
Ward		3		2	6	13	24
Former Ward						1	1
Return Home		4					4
Open Placement						1	1
Open Intact		2		2		5	9
Closed Intact						1	1
Split Custody				1	4		5
Child of Ward				2	1		3
Preventative Services/Extended Family		1				2	3
Child Welfare Services Referral		1				2	3
Total		20	1	13	33	44	111

* This was the primary reason for OIG investigation. Six cases met multiple criteria.

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

County**	Homicide	Suicide	Undetermined	Accident	Natural	TOTAL
Adams			1			1
Champaign				1	3	4
Clinton					1	1
Coles					1	1
Cook	10		9	13	21	53
DeWitt	1					1
Douglas					1	1
DuPage					1	1
Edgar					1	1
Grundy					1	1
Hamilton				2		2
Kane				1	1	2
Kendall				1		1
Lake	1	1		1	1	4
LaSalle					1	1
Marion			1			1
McLean					1	1
Madison					2	2
Peoria	2			1	2	5
Perry				1		1
Rock Island					2	2
St. Clair	5		1			6
Saline				1		1
Sangamon			1			1
Tazewell					1	1
Vermilion	1			2	1	4
Warren				1		1
Will				2	1	3
Winnebago				6	1	7
TOTAL	20	1	13	33	44	111

** Some children died in counties outside of their county of residence.

Table 4: CHILD DEATHS BY SUBSTANCE EXPOSURE STATUS AND MANNER OF DEATH

Substance exposure	Homicide	Undetermined	Accident	Natural	TOTAL
Child exposed at birth***	1	3	4	4	12
Mother has history of substance abuse	3	3	3	3	12

*** This includes only those children who actually tested positive for a substance at birth. Others may have been exposed to drugs during their mother's pregnancy, but the drug use was not recent enough to cause the newborn to test positive.

FY 2007 DEATH BREAKDOWN BY MANNER OF DEATH

Homicide

Twenty (20) deaths were classified homicide in manner.

Cause of death	Number
Gunshot wounds	5
Abusive head trauma	5
Stab wounds	3
Abdominal injury due to blunt trauma	1
Drowning	3
Suffocation/Asphyxia/Strangulation	2
Improper C-Section	1
TOTAL	20

Perpetrator information:

Perpetrator	Number of deaths
Father	1
Mother	2
Step-father	1
Mother's Boyfriend	2
Uncle	1
Aunt's Boyfriend	1
Foster Brother (cousin)	1
Family Friend (non-caregiver)	5
Unrelated Peer	2
Unrelated Adult	1
Unknown/Unsolved	3

Perpetrator sex	Perpetrator age range	Charges
9 Male	14-37	7 were charged with 1 st degree murder, all are awaiting trial*
4 Female	14-24	3 were charged with 1 st degree murder and await trial; 1 was found guilty of 2 nd degree murder in juvenile court**
3 Unknown		

*There were no charges in three of the deaths

**One female was charged with four children's deaths

Suicide

One (1) death was ruled suicide. The cause of death was hanging.

Undetermined

A death is classified as undetermined in manner when there is insufficient information to classify the death as homicide, suicide, accident or natural. This situation usually arises because of deficiencies in investigation, most of which are impossible to overcome. When a case is classified as undetermined, the decision usually lies between two of the four possible manners of death. In nearly all cases involving

infants and children the decision rests between homicide and two other possible manners: accident and natural.

Thirteen (13) deaths were classified undetermined in manner.

12 cases had an undetermined cause

1 case had a cause of drowning

Accident

Thirty-three (33) deaths were classified accident in manner.

Cause of death	Number
Asphyxia/sleep related deaths	9
Suffocation	2
Fire related deaths	7
Drowning	2
Motor vehicle related deaths	3
Auto/Train Striking pedestrian	5
Injuries due to fall	3
Heat stress	1
Blunt trauma	1
TOTAL	33

Natural

Forty-four (44) deaths were classified natural in manner.

Cause of death	Number
Sudden Infant Death Syndrome (SIDS)	8
Complications from premature birth	5
Cardiac disease or complications from heart problems	7
Pneumonia or respiratory illness (including asthma)	6
Cancer	1
Cerebral Palsy	5
Muscular dystrophy	1
Multiple Medical Problems	7
Sepsis/Septic Shock	4
TOTAL	44

Homicide

Child No. 1	DOB January 2004	DOD July 2006	Homicide
Age at death:	Almost 2-1/2 years old		
Substance exposed:	No		
Cause of death:	Closed head trauma consistent with being shaken		
Perpetrator:	Mother's boyfriend		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation, Report to the Director 5/31/07		
<u>Narrative:</u> Two-year-old child became unresponsive at home and was taken by ambulance to the hospital where she was pronounced dead following unsuccessful resuscitation attempts. An autopsy revealed head injuries believed to have been inflicted no more than 18-24 hours prior to the child's death. The 20-year-old mother and her 20-year-old boyfriend were the child's only caretakers during that time. The couple's son, born two months earlier, was placed in foster care, where he remains. A year after the child's death, in July 2007, the boyfriend was charged with first-degree murder. He is awaiting trial.			
<u>Prior History:</u> In October 2005, a doctor called the hotline to report suspected abuse of the child. The child had been seen in the emergency room with a bruise on her forehead, black eyes, and bruises on the side of her head. The doctor was suspicious of the mother's explanation that the injuries were caused by one fall into a coffee table. The child was in the care of her mother's boyfriend at the time she sustained the forehead injury. A report was taken for investigation of abuse to the child by her mother's boyfriend. Later that day, another mandated reporter called about the forehead injury and reported seeing prior injuries on the child. The hotline added to the report an allegation of substantial risk of physical injury to the child by her mother. The investigation was unfounded for insufficient evidence with the rationale that: a CT scan was negative for abuse; a long bone scan was negative for abuse; the doctor was unable to say the injuries were from abuse; the doctor had no concern about past abuse; the explanation for the injury was plausible; neither the mother nor boyfriend had a history with DCFS; the maternal grandmother reported that the couple provided excellent care to the child; the investigator witnessed positive interaction between the three; the boyfriend told the mother about the injury right after it happened and the mother and maternal grandmother immediately sought medical care; the child was in day care and would be monitored; and the couple took protective action by removing the coffee table. The child's 20-year-old father was involved in her life, but he was not notified of the investigation or interviewed during it.			

Child No. 2	DOB June 1998	DOD July 2006	Homicide
Age at death:	8 years old		
Substance exposed:	No		
Cause of death:	Multiple stab and incised wounds		
Perpetrator:	Family friend		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u> Twenty-nine-year-old pregnant mother and her 8-year-old son were found stabbed to death in their home. Two younger siblings, ages 1 and 3, were found unharmed. Two older siblings were out of town with relatives. The alleged perpetrator, reportedly a long time family friend, has been charged with six counts of first-degree murder and intentional homicide of an unborn child. He faces the death penalty if convicted. The surviving children are with their father, who was separated from the mother at the time of the murders.			

Prior History: The Department had one prior contact with this family. Eleven months earlier, a neighbor reported that the mother had disciplined her children with a belt and that the 11-year-old previously had marks from a belt. The mother had taken the baby to the emergency room for an ear infection and left the older children with a babysitter. When the mother returned, she was told that the police had come to the home because the 7- and 11-year old children were yelling at a neighbor. The mother admitted to hitting her 7- and 11-year-old children one time with a child's belt on their buttocks over their clothes. The babysitter was present when the children were hit. The 11-year-old reported that the children only got spanked when they were "really bad". She said that usually they were grounded or sent to their room. The investigation was unfounded because the discipline did not rise to the level of abuse.

Child No. 3	DOB January 1995	DOD August 2006	Homicide
Age at death:	11 years old		
Substance exposed:	No		
Cause of death:	Gun shot wound to the head		
Perpetrator:	Unknown		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Eleven-year-old child was playing video games in her father's home when a bullet came through the lone window of the basement and struck her. The child was visiting her father, but had only been in the home a short time before she was shot. Police believe the shots came from the alley and that the shooting was gang-related, but that the people inside the home were not the targets. As of December 2007, this child's homicide is still an open investigation with the local police department. No one has been arrested for the crime.

Prior History: There was a pending DCP investigation against the child's 29-year-old mother for neglect of her five children, ages 7, 8, 9, 11, and 12. An anonymous reporter had called the hotline alleging the home smelled of marijuana and was roach infested with trash all over the floor, that one of the children was scheduled for surgery related to marijuana smoke, that the children roamed the street late at night and drank alcohol, and that the mother had a drug and alcohol abuse problem. Prior to the 11-year-old's death, the child protection investigator had observed the home and interviewed the mother and children. The home was clean and did not smell of marijuana, the 7-year-old was scheduled for surgery for an injury he sustained when he cut himself on a can lid, the children appeared well-cared for and were in summer programs, and the mother had a certificate showing she had successfully completed a substance abuse program. The investigation was ultimately unfounded.

Child No. 4	DOB July 2006	DOD August 2006	Homicide
Age at death:	1 month		
Substance exposed:	No		
Cause of death:	Multiple injuries due to blunt trauma		
Perpetrator:	Maternal uncle		
Reason For Review:	Open extended family support services case at time of infant's death		
Action Taken:	Investigatory review of records		

Narrative: Fifty-year-old maternal grandmother found her 1-month-old granddaughter unresponsive in the morning and called 911. An autopsy revealed numerous injuries to the infant, including a skull fracture, broken ribs, a broken leg, and a lacerated liver. A 25-year-old maternal uncle, who had been caring for the children while his mother was gone most of the previous day, admitted to police that he caused the infant's injuries. The uncle was charged with murder. He was indicated for abuse in the child's death and for substantial risk of physical injury to his surviving nieces and nephews. Following the infant's death, a short-term intact family case was opened until March 2007.

Prior History: The 30-year-old mother has given birth to six children in the last 10 years. There have been two extended family support services cases open. The first was open from August 2000 until November 2000, and the second was opened in June 2005 and remained open at the time of the infant's death. The maternal grandmother had received guardianship of all the children except the new baby. She reported that the infant had been in her care for the past 2-1/2 weeks.

Child No. 5	DOB April 1991	DOD September 2006	Homicide
Age at death:	15 years old		
Substance exposed:	No		
Cause of death:	Shotgun wound of the head		
Perpetrator	Unknown		
Reason For Review:	Open intact family case within a year of the teenager's death		
Action Taken:	Investigatory review of records		

Narrative: Fifteen-year-old child was shot shortly before 10:00 p.m. on a Sunday evening while he was standing with friends on the front porch of a neighbor's house, just feet from his own home. He was shot 4 times with a shotgun by an unidentified person who approached the friends. Police believe the shooting was gang-related, but do not believe the deceased was the intended victim. The teenager was not a member of a gang, but hung around with gang members. The teenager was drunk (twice the legal limit) at the time he was shot. This death is still an open investigation with the local police department.

Prior History: The deceased's 47-year old mother has a history with DCFS dating to 1993. Her three children were in foster care on two different occasions. The children were last returned to their mother's care in 2003 and were monitored by the court/DCFS until July 2004. They do not have relationships with their fathers. An intact family case was opened on the deceased and his 17-year-old sister in January 2005, following an episode in which the 17-year-old had to contact the police because her mother was so drunk she couldn't wake her (the oldest sibling no longer lived at home). The mother and her children reported she relapsed after 3 years of sobriety. The intact family case was closed in April 2006. At that time, the mother was working and had appropriate housing for herself and her two children. She had negative urine screens, had a sponsor, and was attending AA meetings.

Child No. 6	DOB July 2006	DOD September 2006	Homicide
Age at death:	2 months old		
Substance exposed:	No		
Cause of death:	Subarachnoid and subdural hematoma and diffuse axonal injury of brain and rib fractures (shake injury)		
Perpetrator	Father		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation pending for inclusion in a cluster report		

Narrative: Two-month-old infant was brought to the hospital after he became unresponsive at home. His 21-year-old father reported that he was feeding the baby when the baby stopped breathing. Bruises were apparent on the baby, and he was airlifted to another hospital where his severe head injuries were discovered. The infant died five days later. The father was charged with first-degree murder and aggravated battery of a child. His trial is scheduled for early 2008. The father also was indicated for the baby's injuries and death. The infant had been seen approximately six times at the pediatric clinic and emergency room during his two months of life for normal new baby worries, including feeding, constipation, coughing and sneezing. The medical professionals did not note any concerns about abuse or neglect to the infant.

Prior History: The deceased was an only child. A month before his death, the father called the hotline alleging that the 18-year-old mother had abused the baby. He said that two days earlier he noticed 3 fingerprints in the center of the child's back and a bruise on the child's lower left leg. He reported that the mother said the baby sustained the leg bruise when he got his leg stuck in the crib rail. A report was taken for investigation of cuts, bruises, welts to the infant by neglect of his mother. A Sheriff's deputy responded that night and saw two small bruises on the child's back. A DCP investigator went to the home the next morning and observed the bruise on the baby's leg, but found no bruises on his back. The investigator spoke with the father who said he no longer believed the mother harmed their son. Since making the report, he had witnessed the infant stick his leg through the crib rail, and he now thought he may have caused the back bruises by picking the infant up too quickly to get him away from the dog, who had become agitated. The father reported being frustrated with the mother because, while she helped care for the baby, she did not help with the household chores. The investigator interviewed the mother who denied harming the child or knowing how the bruises on the baby's back were caused. The investigator observed the baby's crib. He spoke with the maternal aunt and maternal and paternal grandmothers. The relatives reported seeing the infant frequently and having no concerns that either parent was physically abusing him, and the investigation was unfounded.

Child No. 7	DOB September 2006	DOD September 2006	Homicide
8	DOB December 2004	DOD September 2006	Homicide
9	DOB September 2003	DOD September 2006	Homicide
10	DOB May 1999	DOD September 2006	Homicide

Age at death: 0, 1-1/2, 2-1/2, 7 years
 Substance exposed: No
 Causes of death: Stillborn fetus extracted by crude C-section performed improperly resulting in fetal demise / Drowning with toxic levels of drugs in their systems which contributed in death
 Perpetrator: Family Friend
 Reason For Review: Open Return Home Case
 Action Taken: Investigatory review of records

Narrative: A 23-year-old mother was murdered when a close friend cut her 28-week-old fetus out of her womb. The child was pronounced dead at a local hospital after the 24-year-old woman brought the infant there, claiming to have delivered the infant herself. A criminal investigation ensued, and the woman later admitted to drowning the mother's three children, ages 1-1/2, 2-1/2, and 7. The woman has been charged with four counts of first-degree murder and one count of intentional homicide to the 7-month-old fetus. Prosecutors have said they will seek the death penalty for the woman if she is convicted in the children's murders.

Prior History: The perpetrator has two children, ages 8 and 9. They were in foster care from 1999 until 2001 because the younger child was abused by her mother. After the children returned home, there was no further DCFS involvement until the murders. Following their mother's arrest, the children entered foster care again. In August 2007, the court granted guardianship of the children to their aunt. The deceased mother had an open case at the time of her and her children's deaths. In January 2005, the mother had beaten her 5-year-old son with a belt as a form of discipline. Her three children entered foster care at that time. The mother and children participated in services, and the two younger children were returned home in December 2005. The oldest child was returned home in May 2006 and the family was receiving after-care (return home) services and monitoring at the time of their deaths. The children's father visited them regularly.

Child No. 11	DOB May 2006	DOD September 2006	Homicide
Age at death:	3-1/2 months old		
Substance exposed:	No		

Cause of death:	Craniocerebral Injuries due to Blunt Head Trauma
Perpetrator:	Aunt's boyfriend, alleged
Reason For Review:	Unfounded DCP investigation within a year of child's death; open intact family case at time of child's death; and two pending DCP investigations at time of infant's death
Action Taken:	Full investigation, Report to the Director 6/29/07
<u>Narrative:</u>	Three-and-a-half-month-old infant was found not breathing when her mother went to check on her. She was taken to the hospital by paramedics and was pronounced dead. Later, the aunt reported that her 29-year-old boyfriend grabbed the baby from her bassinette and threw her back in it because he resented the time she was spending with the baby. The boyfriend has been charged with first-degree murder.
<u>Prior History:</u>	The infant was born to a 20-year-old mother with severe developmental delays. The hotline was called because social workers did not believe that the mother was capable of caring for the infant. The infant lived with her mother and grandmother, both of whom had severe developmental delays, her grandfather, her aunt and her aunt's boyfriend, and their daughter. The investigation was unfounded because the investigator determined that the aunt and grandfather were capable of caring for the infant, but the case was opened for intact family services. Ten days before the infant was killed, the hotline was contacted by a mandated reporter who said that she had seen a suspicious bruise on the child's face. One week later, the hotline was called again with a second report of bruising to the child. Both bruising investigations were pending when the infant was murdered.

Child No. 12	DOB October 2006	DOD October 2006	Homicide
Age at death:	0		
Substance exposed:	No		
Cause of death:	Suffocation (as determined by confession)		
Perpetrator:	Mother		
Reason For Review:	Pending DCP investigation at time of newborn's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u>	Fourteen-year-old mother suffocated her newborn baby and placed her in the garbage so her adoptive mother would not find out about the pregnancy and birth. The mother was found guilty in juvenile court of second degree murder and concealing a homicide. She was also indicated for death by abuse to the infant. The infant, who was born at an estimated gestational age of between 28 and 32 weeks, would have died within hours of her birth without medical intervention.		
<u>Prior History:</u>	Nine days prior to the infant's death, the adoptive mother's 13-year-old daughter told a worker that her adoptive mother hit her and accidentally hit the 13-year-old's 1-week-old baby. A DCP investigation alleging substantial risk of physical injury to the 13-year-old and her baby by the adoptive mother was ultimately unfounded, but an intact family case was opened to address issues uncovered during the DCP investigations involving the teens. The case remains open.		

Child No. 13	DOB December 1993	DOD November 2006	Homicide
Age at death:	12-1/2 years old		
Substance exposed:	Unknown, mother has a history of cocaine use		
Cause of death:	Stab wound of the neck involving the left lung		
Perpetrator:	Unrelated Female Peer		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: At approximately 9:30 p.m., the deceased's 16-year-old sister got into a verbal dispute with an 18-year-old female while standing outside her home. The dispute became physical and the 18-year-old pulled a knife and stabbed the 16-year-old in the arm. The 16-year-old's little sister intervened to protect her, and she was fatally stabbed in the neck. The alleged perpetrator was arrested and charged with a variety of offenses, including first-degree murder. She is awaiting trial, and her next court date is in January 2008.

Prior History: DCFS became involved with this family in February 2006 when the 34-year-old mother gave birth to her seventh child. The child was born substance-exposed. The mother reported that she had been clean for over ten years, but relapsed in 2004 after her 16-year-old son was gunned down on a basketball court. An intact family case was opened to provide the mother with substance abuse services, and the family with grief counseling, both of which were occurring at the time of the 12-year-old's murder. The family's case was closed in June 2007 because the mother was not participating in services. The children were not determined to be at risk because the older siblings (ages 20, 16, and 15) were stepping in for their mom when necessary to care for their younger siblings (ages 11 and 1). Two of the girls' fathers were also helping the family.

Child No. 14	DOB October 2003	DOD December 2006	Homicide
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Age at death:	3 years old
Substance exposed:	No
Cause of death:	Massive soft tissue blunt trauma to the lower extremities and abdomen
Perpetrator:	Mother
Reason For Review:	Child welfare services referral within a year of child's death
Action Taken:	Investigatory review of records

Narrative: Three-year-old boy was found badly bruised and deceased by police, who responded to a call from relatives. The boy was in the care of his mother at the time of his death. In June 2007, the mother gave birth to her second child who was immediately placed in foster care. In August 2007, the mother was charged with first-degree murder.

Prior History: The 20-year-old mother was involved with DCFS as a child beginning at the age of 3. She entered foster care at the age of 12 and was placed in the subsidized guardianship of an aunt at age 16. In October 2006, the Department received a request from the police to assess the mother and her child for services. The police had received a report of a child home alone. When they responded, they found the mother unconscious lying down in the tub with the shower running. She was transported to the hospital where she reported that she fainted. Tests were conducted, and the mother was informed that she was one month pregnant. The child welfare worker obtained the mother's emergency room record, talked to the mother and her father, observed the child, and conducted a home safety checklist. No services were recommended.

Child No. 15	DOB August 1986	DOD December 2006	Homicide
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Age at death:	20
Substance exposed:	Unknown, mother has a history of substance abuse
Cause of death:	Multiple gunshot wounds
Perpetrator:	Unknown
Reason For Review:	Deceased was a ward
Action Taken:	Investigatory review of records

Narrative: Twenty-year-old ward was outside with a group of people two houses down from his aunt's home. A fight broke out around 1:15 a.m., and the ward was shot multiple times. He was taken to a local hospital where he was pronounced dead. The ward had a gun in his jacket pocket. Police have questioned suspects, but no one has been charged.

Prior History: The deceased's 45-year-old mother has been involved with DCFS multiple times since 1994 because of problems stemming from substance abuse. Her six children entered foster care in 2002. They returned home in 2003, but came back into foster care a few months later. The deceased spent much of the next three years in and out of the criminal justice system. He was paroled to his aunt's home just two days before being shot. In 2005, the youngest sibling was placed in the care of her father, and the other four returned home to their mother. An intact family case was opened on the family in November 2006. It remains open. The deceased did not see his father. He did see his mother, who attended his court hearings and encouraged him to participate in services.

Child No. 16	DOB February 1993	DOD January 2007	Homicide
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Age at death:	13 years
Substance exposed:	No, however, mother has a history of substance abuse
Cause of death:	Stab wound to the chest
Perpetrator:	First-cousin's son (foster brother)
Reason For Review:	Deceased was a ward
Action Taken:	Full investigation pending, Interim Report to the Director 10/30/07

Narrative: Thirteen-year-old ward, who had been placed in the licensed foster home of his first cousin since June 2006, was stabbed and killed by his cousin's 14-year-old son (his first cousin once removed). The cousin went to work and left the ward and her son at home with her 4-year-old daughter. The foster mother reported that a relative was en route to baby sit and the incident occurred during a 15-minute lapse in supervision. The 14-year-old told police that his cousin struck him with a pipe, and he turned around and stabbed the boy. The 14-year-old had a defensive wound on his elbow. The police and State's Attorney's office determined the boys were "mutual combatants", and no charges were brought against the 14-year-old. The 4-year-old child witnessed the incident. The foster parent-cousin was indicated for inadequate supervision and death by neglect to the ward, and her son was indicated for death by abuse to the ward and substantial risk of physical injury to his sister.

Prior History: The ward entered foster care in July 2003 when at 10 years old he stabbed his 12-year-old brother. Both boys had mental health issues and a history of aggression, and they had been psychiatrically hospitalized two months prior to the incident. The 30-year-old mother admitted that she had not dispensed the children's psychotropic medication to them. The mother was indicated for wounds by neglect, inadequate supervision, and substantial risk of physical injury to her 1 and 4-year-old sons. Both of the older boys entered foster care. The two younger children were allowed by the court to remain at home.

Child No. 17	DOB November 2003	DOD April 2007	Homicide
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Age at death:	3 years old
Substance exposed:	No
Cause of death:	Complications of closed head injuries due to blunt force trauma
Perpetrator:	Mother's boyfriend
Reason For Review:	Pending DCP investigation at time of child's death
Action Taken:	Investigatory review of records

Narrative: Three-year-old child was taken to the hospital by ambulance after becoming unresponsive at home while his mother's 32-year-old boyfriend was babysitting him. The mother was at work. Three of the boyfriend's four children also were in the home as was his 15-year-old brother. The child was airlifted to a children's hospital where he later died from inflicted head injuries. The boyfriend allegedly assaulted the child because he was fighting with another child over a toy. The boyfriend was charged with first-degree murder and aggravated battery to a child. He is awaiting trial. The boyfriend also was indicated for the injuries to the child and the child's death in addition to substantial risk of physical injury to two of his own children who were in the home. The 22-year-old mother was indicated for substantial risk of physical injury by neglect to the deceased because she left him in the care of her boyfriend after he physically assaulted her, and she lied during a pending DCP investigation, stating to the investigator on two occasions that she did not know where her boyfriend was, she had not seen him in days, and he had not had any contact with her son.

Prior History: There was a pending DCP investigation at the time of the child's death. Nine days earlier the police were called after the paramour pushed, scratched, and slapped the mother at a restaurant while the child was present. The child was uninjured and the paramour fled the scene before the police arrived. The hotline was notified, and it took a report of substantial risk of physical injury to the child by the paramour. Six days later, the investigator saw the mother at her home. The mother said she did not know where her boyfriend was. She denied that her boyfriend hurt her at the restaurant or anywhere else during their year-long relationship. The investigator saw the child who had a cast on his arm. The mother reported that the child fell off his bunk bed, and he was due to have the cast off in a couple of days. The investigator met with the mother again the following day. The mother said she had not spoken with her boyfriend and heard that he was in Indiana. The mother again denied domestic violence, even after being confronted with the police report of the incident. The investigator cautioned the mother about her previous history of domestic violence and the risk to herself and her child. The investigator saw the child, who was watching a movie. The investigation was pending when the child died the following day. Medical records for the child's broken arm did not reveal an explanation, however, no concerns about abuse or neglect were noted in them. The child's 29-year-old father was very involved with him during the child's first year of life, but he had not seen the child in the past six months.

Child No. 18	DOB June 1990	DOD April 2007	Homicide
Age at death:	16 years old		
Substance exposed:	No		
Cause of death:	Multiple gunshot wounds		
Perpetrator:	Unrelated adult		
Reason For Review:	Deceased was a ward		
Action Taken:	Preliminary investigation		
Narrative: Sixteen-year-old ward ran away from his group home. Four days later his body was discovered by a woman walking her dog. The ward was in a gangway approximately ten houses down from his group home. He was identified by a staff member of the group home. The pathologist who conducted the autopsy determined the ward had died the day before. He had been shot multiple times. The ward's group home had reported him missing to the police four days earlier. An adult was arrested and charged in April 2007 with first-degree murder in the death of the 16-year-old. The case is still pending trial.			

Prior History: The ward was the youngest of 5 children. His eldest brother died when the ward was seven. His family became involved with DCFS the following year after his 37-year-old mother began using cocaine. His father is deceased. In July 2002, the juvenile court found the child delinquent, ordered him into treatment, and placed him on probation until July 2007. The court also found the child dependent because no family member came to court. He was placed in the guardianship of DCFS. During the five years he was in custody, the ward ran frequently from his placements. In November 2006, he was placed in the group home where he remained until his death. While he repeatedly left this placement, he usually returned within 24 hours. When he ran from the placement, the agency would comply with the Department's runaway protocol.

Child No. 19	DOB July 1991	DOD April 2007	Homicide
Age at death:	15 years old		
Substance exposed:	No		
Cause of death:	Gun shot wound of the back		
Perpetrator	Unrelated peer, believed to be gang-related		
Reason For Review:	Unfounded DCP investigation within a year of teenager's death		
Action Taken:	Investigatory review of records		
Narrative: Fifteen-year-old boy was walking down the street at approximately 7:00 a.m. when a car pulled up to him, and someone in the car shot him. Witnesses took the boy into a store and called 911. The boy was pronounced dead at a local hospital. The boy was in a gang. An unrelated peer, believed to be a rival gang member, was arrested, but not charged in the shooting.			
Prior History: Three months prior to the boy's death, the hotline was called with a report that the boy had shot himself in the hand and was in the hospital. The reporter alleged neglect, stating the boy's mother knew he had a gun and did nothing about it. The report was unfounded because both parents expressed appropriate concern for their son and denied knowing their son had a gun. The boy and his two sisters confirmed that their parents did not know the boy had a gun. The parents admitted knowing their son was in a gang. They explained that he joined a rival gang after being harassed and beat up by gang members several times. The parents had been trying to get him to leave the gang and had pleaded with the boy's school for a transfer, which was denied. The boy was charged with unlawful possession of a firearm and placed in a detention center. He told the investigator that he was changed by being shot, and he was going to talk to his mother about staying out south with family members.			

Child No. 20	DOB December 1990	DOD May 2007	Homicide
Age at death:	16 years old		
Substance exposed:	Yes, cocaine		
Cause of death:	Strangulation		
Perpetrator	Step-father		
Reason For Review:	Unfounded DCP investigation within a year of teenager's death		
Action Taken:	Investigatory review of records		
Narrative: Sixteen-year-old girl was strangled to death by her 66-year-old step-father. The girl was cursing when her step-father came into the room and said he was tired of her behavior and told her to leave. When she refused, he grabbed her and threw her down on the couch. When she started to fight back, the step-father put his hands around her neck and began to choke her. He held her down with his body and continued to strangle her even when she screamed that she couldn't breathe. The girl's 65-year-old adoptive mother, who is wheel-chair-bound, yelled for him to stop. Several family members were present but none of the family members intervened. The step-father and at least two other family members called 911. The State's Attorney's Office has not charged the step-father. The adoptive mother left the step-father, and she and the deceased's brother went to live with relatives.			

Prior History: The deceased and her sibling were born substance-exposed. They were adopted by an aunt in 1994, and three more siblings were adopted by other relatives. There were two prior unfounded child protection investigations involving the deceased and her step-father. In October 2005 and January 2007, the teenager alleged that her step-father had come on to her once (the same occasion), but that he did not touch her. When later questioned by authorities, the teenager recanted her allegation and the investigations were unfounded for insufficient evidence.

Suicide

Child No. 21	DOB December 1990	DOD September 2006	Suicide
Age at death: 15 years old Substance exposed: No Cause of death: Hanging Reason For Review: Unfounded DCP investigation within a year of teenager's death Action Taken: Investigatory review of records			
Narrative: Fifteen-year-old child was found in the afternoon by his siblings hanging by a bed sheet from a ceiling rafter in the basement of the family's rental home. The child's bedroom was in the basement. Earlier that day, the 36-year-old mother had hit the child with a curtain rod for not doing his chores. The child's grandfather had passed away a few days earlier. Family members and the child's teacher were shocked by the child's suicide. The child's death was the third in a string of three suicides at the child's high school. Following his death, the school assessed students at the school for depression. Nine children were hospitalized, and twelve more were referred for services.			
Prior History: The deceased was one of seven siblings born to his parents. The children lived with their mother. In 2005, a paramour of the mother was indicated for cuts, bruises, welts to a younger sibling of the deceased. He was unfounded that same year for inadequate supervision of the same child. In February 2006, the hotline was called to report that two of the deceased's siblings were coming to school hungry and asking for food. An investigation of inadequate food was unfounded because an investigator observed plenty of food in the home, the children appeared healthy, and the girls reported that they had enough to eat at home.			

Undetermined

Child No. 22	DOB January 2003	DOD July 2006	Undetermined
Age at death: 3-1/2 years old Substance exposed: No Cause of death: Undetermined Reason For Review: Unfounded DCP investigation within a year of child's death Action Taken: Investigatory review of records			
Narrative: Three-and-a-half-year-old child was found unresponsive in the morning by his 28-year-old mother and his 36-year-old father. The parents reported that the child had a fever and a seizure early that morning, and they put cold rags on his head and the fever broke. The child had been sleeping in bed with them and when they awoke, he was unresponsive. The child did not have a history of seizures, but a 6-year-old sibling did. An autopsy failed to reveal a cause of death for the child.			

Prior History: The deceased lived with his mother, father, and two older half-brothers. His mother has had involvement with DCFS since 2000, and the boys were in foster care from June 2004 until July 2005. In April 2006, the court returned guardianship of the children to their mother and the DCFS case was closed. One month later, the hotline was called with an allegation of medical neglect to the oldest boy. The 7-year-old child's teacher reported that the mother had been asked to take the child to the doctor for exhibiting autistic and obsessive compulsive behaviors, and the mother had not done so. The investigation was unfounded because the child had been evaluated two months earlier by a psychiatrist and had also been seen by his primary care physician who was overseeing the child's medications.

Child No. 23	DOB May 2006	DOD August 2006	Undetermined
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Age at death:	3 months old
Substance exposed:	No
Cause of death:	Undetermined
Reason For Review:	Pending DCP investigations at time of infant's death
Action Taken:	Full investigation pending for inclusion in a cluster report

Narrative: Fifteen-year-old mother put 3-month-old infant in bed with her at approximately 1:30 am. When she awoke just after 9:00 am, she found the infant unresponsive. The infant's 39-year-old maternal grandmother, with whom he and his mother lived, called 911 and the infant was transported to the hospital where he was pronounced dead. DCFS investigated and unfounded the mother for death by neglect of the infant. An autopsy failed to reveal a cause of death. While there was no evidence that the mother rolled over on the infant (there rarely is), it could not be ruled out and the cause of death was undetermined.

Prior History: The maternal grandmother has two children, the 15-year-old and a 7-year-old. The family has been involved with DCFS since 2002. At the time of the infant's death, there were 17 DCP investigations involving the family, 3 of which were pending. Intact family cases were opened and closed 3 times since 2002. Following the infant's death, protective custody was taken of the 7-year-old child. Custody was returned to his mother a few days later after the State's Attorney's Office refused to screen his case for court involvement, advising the Department it should provide intact family services. Intact family services were provided to the family through August 2007. The family is receiving services indefinitely through a Department of Housing and Urban Development program; it is also receiving services from a community mental health agency.

Child No. 24	DOB April 2006	DOD September 2006	Undetermined
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Age at death:	4 months old
Substance exposed:	Yes, cocaine and cannabis
Cause of death:	Undetermined
Reason For Review:	Child was a ward
Action Taken:	Full investigation, Report to the Director 6/26/07

Narrative: Four-month-old infant was found unresponsive by a 19-year-old cousin who was caring for him. The cousin had fed the baby and put him to sleep for the night. When she later checked on him, he appeared blue and was not breathing. She called 911 and attempted to resuscitate the baby. When paramedics arrived, they took over and transported the baby to the hospital where he was pronounced dead. The bassinette in which the baby was sleeping was filled with blankets and the cousin reported that the baby had a blanket pushed up around his face. In addition the baby had an abrasion on his nose.

Prior History: The deceased was born prematurely and substance-exposed at 32 weeks gestation. He entered foster care after his release from the hospital, along with his 1-year-old sister. The deceased was his 22-year-old mother's fifth child. The mother has a history with DCFS dating to 2001. The maternal grandmother has guardianship of the oldest child and the next two children were adopted in February 2005. Upon entering foster care, the deceased child and his 1-year-old sister were also placed in the home of the maternal grandmother until she informed DCFS that she was no longer interested in providing care for the two minors. A Juvenile Court Judge awarded guardianship of the deceased and his 1-year-old sister to DCFS in May 2006 at which time the two were placed in relative care with paternal relatives. In June 2006, the two minors were moved to a traditional foster care placement. Four days after being placed in the non-relative home, the maternal grandmother filed a Petition for Appointment of Guardian of the Person of the Minors in Probate Court. Five days later, a Probate Court Judge granted maternal grandmother private guardianship of the two minors. The maternal grandmother provided DCFS with the Probate Court order and the children were returned to her care. The conflicting orders (the juvenile court order granting guardianship to DCFS and the probate court order granting guardianship to the maternal grandmother) were in effect for over a month until the Probate Court order was set aside. The children remained in maternal grandmother's physical custody because no one from the Department knew about the second order vacating the maternal grandmother's guardianship, and everyone incorrectly believed that maternal grandmother was still the guardian.

Child No. 25	DOB February 1994	DOD September 2006	Undetermined
Age at death:	12 years old		
Substance exposed:	No		
Cause of death:	Undetermined		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
Narrative: Twelve-year-old child, who suffered from asthma, was at home with his family watching a movie when he began having trouble breathing. He was told to use his inhaler and when that didn't help, his 28-year-old guardian told him to sit in front of the air conditioner. When that didn't help, the child's guardian and his 34-year-old mother put him and his four siblings in the van and headed for the hospital. The child stopped breathing on the way, and they stopped at a friend's house for help. Paramedics were then called, and the child was taken by ambulance to the hospital where he was pronounced dead. The child's death was ruled undetermined because while the history of his acute onset of asthma included use of an inhaler, no trace of therapeutic drugs was found in his body.			
Prior History: The deceased was the second born of his mother's five children. In 2004, the mother was indicated for inadequate supervision of her 3-year-old twins after she left them at a YWCA housing facility without supervision while she brought her other children to school. Two months later, she was indicated for substantial risk of physical injury when she took too much stolen pain medication while caring for her children. The Department offered the mother services, but she declined and moved out of town. A worker went to see the family in their new home, and the mother again declined services. In July 2006, the mother designated a friend as the deceased's guardian. The child's 43-year-old father, with whom he had a relationship, had DCP investigations unfounded in December 2005 and June 2006 for substantial risk of sexual injury to his girlfriend's daughter and to the deceased based on his status as a registered sex offender. When the father was 30 years old, he had sex with a 16-year-old girl, whom he stated he thought was older. He had not committed any further sex offenses since that time.			

Child No. 26	DOB August 2006	DOD September 2006	Undetermined
Age at death:	1 month old		
Substance exposed:	No, but the mother has a history of substance abuse		
Cause of death:	Undetermined		
Reason For Review:	Open intact family case within a year of child's death		

Action Taken: Full investigation pending for inclusion in a cluster report

Narrative: One-month-old premature twin baby was found unresponsive by her 24-year-old mother. The baby had been released from the hospital five days earlier while the other twin remained in the hospital. The mother reported that she fed the baby at 4:00 am, and then they both fell asleep in the parents' bed. The mother awoke around 7:20 am and found the baby unresponsive. The baby's autopsy noted that the possibility of traumatic asphyxia could be neither proved nor disproved, thus the undetermined cause of death. The child's death was not investigated by DCFS because there were no allegations that it was caused by abuse or neglect. An investigation for substantial risk of physical injury to the 2 children in the home was unfounded, but a preventive services case was opened following the infant's death. It remains open.

Prior History: The twins were the mother's third and fourth children, but the first for their 24-year-old father. The mother has a history with DCFS dating to her childhood, when she was made a ward under a dependency petition. She had multiple placements because of mental health issues and behavior management problems. She was placed in independent living for 1-½ years before she aged out of the system at 19 years old. In 2003 the Department opened a preventive services case for three months when the mother requested assistance with housing. The next contact was in 2004 when the mother slapped her 2-year-old child in the mouth and commented that she felt like shaking her 1-month-old baby. She was indicated for substantial risk of physical injury, and substance abuse problems were identified. An intact family case was opened, during which the children were placed for a month under a dependency petition. The mother's participation in services was sporadic until June 2005, when following a hospitalization, the mother agreed to informally place her children with their respective paternal grandparents and enter residential substance abuse treatment. The mother completed treatment and parenting classes, attended mental health counseling, worked on her financial issues, and secured housing. Her children were gradually returned to her care, and the intact family case was closed in January 2006. In February 2006, an investigation was initiated following a call to the hotline by a relative of the mother's boyfriend, who expressed concern about the mother's mental health and substance abuse history. The investigation was unfounded because the mother had recently completed treatment and demonstrated competence in caring for her children.

Child No. 27	DOB September 2006	DOD September 2006	Undetermined
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Age at death:	Almost 2 weeks old
Substance exposed:	No
Cause of death:	Undetermined
Reason For Review:	Unfounded DCP investigation within a year of infant's death
Action Taken:	Investigatory review of records

Narrative: Twelve-day-old baby was found unresponsive on a twin bed by her 31-year-old father. The father had laid the baby to sleep on her stomach on a twin bed. He reported that he was sleeping with only his torso on the bed and his legs on a footstool. During the night a family member woke the father and advised him to put the baby on her back. The father did, but he found the baby unresponsive on her back in the morning. The baby's death was undetermined because of the sleeping arrangements; asphyxia could not be ruled out as a cause. At the time of her death, the baby was staying with her father who, along with his 8-year-old daughter, lived with the baby's paternal grandmother, step-grandfather, adult sister and the grandparents' five adopted children. The grandparents are licensed foster parents, but at the time of the infant's death no wards were placed in their home. The father shared custody of the baby with the 27-year-old mother.

Prior History: The prior involvement in this case involved the child's mother. In August 2006, an anonymous reporter called the hotline with concerns of environmental neglect to the mother's 9-year old daughter who had just moved in with her mother after living with her grandmother out of state for several years. The family was reported to be living in a filthy home infested with roaches, fleas and rats. The DCP investigator assigned to the case went to the address reported, but the address did not exist. The investigator found another address for the mother using the Department of Healthcare and Family Services database. The investigator went to the home and was told by the owner that the mother and daughter had stayed at the home temporarily, but had moved to a shelter. The homeowner also said that she had no concerns about the mother; she appeared to have a good relationship with her daughter and ensured that the child's needs were met. The investigator located the mother, daughter and by then, newborn baby, at the shelter and noted the children appeared healthy. The mother acknowledged that she had stayed at a home near the original reported address, but left because of roaches and general unseemliness. The investigation was unfounded because the mother and children were safely residing in a shelter.

Child No. 28	DOB June 2006	DOD October 2006	Undetermined
Age at death: 4 months old			
Substance exposed: Yes, cocaine and methadone			
Cause of death: Undetermined			
Reason For Review: Open intact family case at time of infant's death			
Action Taken: Investigatory review of records			
Narrative: Four-month-old infant was found unresponsive in the morning in her crib by her 26-year-old mother. The mother and the 24-year-old father took the infant by car to the emergency room where she was pronounced dead. An autopsy failed to reveal a cause of death; the death could not be attributed to SIDS because a scene investigation was not completed.			
Prior History: The infant was born prematurely and substance-exposed. She was the mother and father's third child, and the second child to be born substance-exposed. The mother tested positive for drugs at the births of all three of the children, but only two of the infants tested positive for drugs. An intact family case was opened in November 2004 after the mother gave birth to her first substance-exposed infant. The mother engaged in outpatient substance abuse treatment sporadically, but was still using drugs when the second child was born. The intact family case remained open. The mother was living with the children's father (her husband) and the paternal grandmother, and the children were being well-cared for. At the time of the third child's birth in June 2006, the mother agreed to go to inpatient substance abuse treatment. The mother entered treatment at the end of July with the infant while the two older children remained in the care of their father. The mother left inpatient treatment after a short while and returned to outpatient treatment. The children remained in the care of their father with help from the paternal grandmother. The mother also lived in the home. The two surviving children later entered foster care in June 2007 and were placed with a maternal great-aunt.			

Child No. 29	DOB October 2006	DOD October 2006	Undetermined
Age at death: 13 days			
Substance exposed: Yes, cocaine			
Cause of death: Undetermined			
Reason For Review: Pending DCP investigation at time of infant's death			
Action Taken: Full investigation pending			

Narrative: Thirty-five-year-old mother found her 13-day-old infant unresponsive in the early morning while they were sharing a bed. At the time of the infant's death, there was a pending DCP investigation for substance misuse based on the infant testing positive for cocaine at birth. The infant was the mother's third substance-exposed infant. The mother had agreed to go to inpatient substance abuse treatment with the infant and her 2- and 4-year-old children. The infant had a crib in the home, and before the child died, the mother and 44-year-old father had been cautioned about the dangers of co-sleeping. The infant's death was undetermined because the parents were unavailable for a scene investigation.

Prior History: The mother gave birth to her first substance-exposed infant in January 2002. The baby tested positive for opiates, and the mother was indicated for substance misuse. An intact family case was opened. In April 2004, the mother gave birth to her second-substance-exposed infant. The baby tested positive for cocaine, and the mother was indicated for substance misuse. An intact family case was opened, and the mother completed inpatient treatment with her children. Although the mother tested positive for cocaine on occasion, the intact family case was closed because the children lived with their father and maternal grandmother in addition to their mother.

Child No. 30	DOB January 2007	DOD February 2007	Undetermined
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Age at death:	1 month old
Substance exposed:	No, however mother has a history of substance abuse
Cause of death:	Undetermined
Reason For Review:	Split Custody (siblings in foster care) and Pending DCP investigation at time of child's death
Action Taken:	Investigatory review of records

Narrative: Thirty-eight-year-old mother went to feed her one-month-old baby and found her limp and lethargic. The baby then projectile vomited. The mother took the baby to the hospital where she was admitted after 10 minutes in the emergency room. The baby's heart stopped while she was at the hospital. She was pronounced dead several hours after arriving there. An autopsy did not reveal a cause of death.

Prior History: The mother has a history with DCFS dating to 1994. In 1999, the Department took custody of the mother's five children. One father obtained custody of his child, and a maternal aunt obtained subsidized guardianship of two of the children. The other two remained in foster care. In 2005, the mother gave birth to her third substance-exposed infant. He was placed in foster care. After losing custody of him, the mother successfully completed substance abuse treatment, and she and the child's 50-year-old father participated in counseling, random urine screens, and weekly visits with the boy. When the mother learned she was pregnant with the deceased, she sought prenatal care. She prepared to care for the baby and acquired all the necessary baby items. Because the mother had been drug-free for a year, and she and the father had participated in services, the baby was allowed to remain in her parents' care. Currently, the oldest child in foster care has a goal of independence and the two younger children have goals of return home.

Child No. 31	DOB October 2006	DOD March 2007	Undetermined
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Age at death:	4-1/2 months old
Substance exposed:	No, however mother tested positive for cannabis at infant's birth
Cause of death:	Undetermined
Reason For Review:	Unfounded DCP investigation within a year of child's death
Action Taken:	Full investigation pending

Narrative: Four-and-a-half-month-old infant was found unresponsive in the early morning by her aunt. The 17-year-old mother reported that she had laid the infant to sleep on her back on a couch at 1:30 that morning with a blanket on top of her, and no pillows on the couch. The mother then went to sleep next to the baby. When the aunt checked on the baby at around 4:30 in the morning, she noticed the baby was unresponsive. The baby's cause of death was undetermined because of the child's sleeping arrangements; asphyxia could not be ruled out as a cause of death.

Prior History: When the child was 7 days old, the hospital, where she remained after birth, called the hotline with an allegation of inadequate supervision because the mother failed to pick up the infant upon discharge. The hospital was also concerned that the mother said she was homeless. A DCP investigator unfounded the investigation, determining that the failure to pick up the baby was the result of miscommunication between the mother and the hospital. The investigator visited the mother at her sister's home, where she was staying, and found it to be clean with a fully stocked refrigerator and "tons of new baby items."

Child No. 32	DOB February 2007	DOD April 2007	Undetermined
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Age at death:	Almost 2 months
Substance exposed:	No
Cause of death:	Undetermined
Reason For Review:	Child of a ward
Action Taken:	Investigatory review of records

Narrative: An almost 2-month-old infant was found unresponsive in the morning by his 20-year-old mother. He had been sleeping in his crib. An autopsy did not determine a cause of death, and a scene investigation did not reveal any concerns. The infant's death was ruled undetermined because of some minor inconsistencies in the information obtained by police and the information obtained by the Medical Examiner's Office.

Prior History: The infant's mother has been a ward since 2000 when, upon her release from a hospital, no relatives could be found to care for her. Her mother was recently deceased, and her father's whereabouts were unknown. Although much of her time in foster care had been marked by instability in her placements, the mother recently was attending college, working full-time, and taking good care of her baby. The mother continues to receive support services through DCFS's Youth in College program. She has a 2-year-old child who resides out of state with the child's father.

Child No. 33	DOB April 2007	DOD May 2007	Undetermined
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Age at death:	Three weeks old
Substance exposed:	No
Cause of death:	Undetermined
Reason For Review:	Child's mother was a ward within a year of the child's death
Action Taken:	Full investigation pending for inclusion in a cluster report

Narrative: Twenty-one-year-old mother awoke to find her 3-week-old infant unresponsive. She had been sleeping with the infant and her 1-1/2-year-old daughter on the living room floor under a window where it was cool. She woke her 25-year-old boyfriend up from the bedroom, and he began CPR. When the police and paramedics arrived, the mother reported that she had breastfed the infant and fallen asleep. Later, she explained to the medical examiner investigator that she had breastfed the infant, put the infant face up on a pillow to sleep (to help her breathe) and then fell asleep herself. The mother said that she had been concerned about the baby's breathing since she was born, and she had expressed her concern to the doctor. An autopsy failed to reveal a cause of death, and because of the inconsistencies between the mother's two statements, the cause was declared undetermined. DCFS indicated the mother for death by neglect, relying on an emergency services report stating the mother fell asleep while feeding the baby and woke up on top of her and an emergency room report stating "accidental suffocation". The mother previously had been told by at least 3 professionals that she should not sleep with the baby, and the mother had a crib in the home. An intact family case was opened following the infant's death, and it remains open.

Prior History: The mother is the oldest of ten siblings. Her family first came to the attention of DCFS in 1991 when her 20-year-old mother gave birth to her fourth child, who was born substance-exposed. An intact family case was opened, and the children ultimately all entered foster care. The deceased's mother had a case open with an agency participating in the Teen Parenting Services Network until she aged out of DCFS care at age 21.

Child No. 34	DOB September 1991	DOD June 2007	Undetermined
Age at death:	15 years old		
Substance exposed:	No		
Cause of death:	Drowning		
Reason For Review:	Teenager was a ward		
Action Taken:	Investigatory review of records		
Narrative: Fifteen-year-old ward's body was found floating in a river. The ward had been on run from his residential placement for four days. The ward often left the placement, but rarely more than for a few hours at a time. Staff followed the ward upon his leaving in an attempt to convince him to come back. When the child did not return, the agency contacted family members, filed a police report, obtained a juvenile arrest warrant, and reported the ward to the National Center for Missing and Exploited Children. The child's manner of death was undetermined because, despite a history of psychiatric problems, the medical examiner could not, without further information, determine if the child jumped, was pushed, or accidentally fell into the river.			
Prior History: The child grew up with his mother and grandmother in another state. As a child, the ward experienced mental health problems which required hospitalization; they also caused aggression which resulted in juvenile arrests. In 2005, the mother and the grandmother were incarcerated for assaulting a neighbor with deadly weapons. The child came to Illinois to live with his grandfather. A couple of months later, the grandfather was diagnosed with cancer, and he died in December 2005. A cousin took the child in, but he was unable to handle the child's behavior. In January 2006, the child was made a ward through a dependency petition. After failing in foster homes, the ward was hospitalized and then sent to a residential placement. During his 1-1/2 years with the Department, the ward was in two foster homes and three residential placements and had seven acute psychiatric hospitalizations and one diagnostic psychiatric hospitalization. In residential placement the ward participated in individual, group, and family therapy, eventually making progress toward his goal of being placed back with his cousin. In December 2006, the child was informed of the death of his mother from cancer while she was incarcerated, and he became very aggressive. Over the next six months the ward was hospitalized three times, including a four-month diagnostic placement. The day after the ward left his residential placement, the agency was informed that he was accepted into another, more intensive, residential placement.			

Accident

Child No. 35	DOB February 2005	DOD July 2006	Accident
Age at death: 17 months old Substance exposed: Yes, cocaine and marijuana Cause of death: Anoxic encephalopathy due to drowning Reason For Review: Open intact family case within a year of child's death Action Taken: Investigatory review of records			
<p><u>Narrative:</u> One-year-old toddler died two weeks after nearly drowning in his maternal grandparents' pool. The toddler was with his 20-year-old mother and twin sister at his maternal grandparents' home. His mother was doing laundry in the basement. His aunt was leaving the house through the back sliding glass door and the boy wanted to go with her. She told him he couldn't, and he threw himself down on the ground and had a tantrum. The aunt left, closing the screen door, but leaving the glass door open because it was hot. The maternal grandmother, who overheard the tantrum, thought the boy went downstairs to be with his mother because he was upset. A couple of minutes later, she went into the kitchen and saw the boy's twin coming up the stairs. She noticed the door was open and didn't want the girl to get out. When she went to close the door, she saw the boy face down floating in the pool. She screamed, ran and got him, and someone called 911. The child was hospitalized. While doctors were initially hopeful, the boy was later declared brain dead and transferred to hospice. He died almost two weeks after the incident. The mother was unfounded for inadequate supervision in the child's death.</p>			
<p><u>Prior History:</u> The mother gave birth to the twins at 34 weeks gestation. They both tested positive for cocaine and marijuana at birth. The mother was indicated for substance misuse, and an intact family case was opened. The twins remained hospitalized for a couple of weeks and were released to their mother with the agreement that the mother and children would live with the maternal grandparents while the mother completed substance abuse treatment. The mother completed a substance abuse treatment program, continued to test negative for drugs, and completed a domestic violence program. The twins' 21-year-old father declined to participate in services. The intact family case was closed in January 2006.</p>			

Child No. 36	DOB November 2000	DOD July 2006	Accident
Age at death: 5-1/2 years old Substance exposed: No Cause of death: Multiple injuries due to motor vehicle striking pedestrian Reason For Review: Unfounded DCP investigation within a year of child's death Action Taken: Investigatory review of records			
<p><u>Narrative:</u> Five-and-a-half-year-old child was struck by a van and killed around 10 pm. The child's 55-year-old maternal grandmother was caring for him while his mother worked, and she was unaware that he went outside. The Department indicated the grandmother for neglect in the child's death. The driver of the van was not charged with a crime because police determined the incident was an accident.</p>			
<p><u>Prior History:</u> The deceased was the youngest of four siblings. The month before the child's death the hotline was called by an anonymous reporter who alleged that the child was inadequately supervised as he was seen playing outside as late as 10 pm without adult supervision. The child's 36-year-old mother denied the allegation, stating that she supervised her four children herself when she was not working, and that the maternal grandmother supervised them when she was at work. The children and the maternal grandmother also denied that the child was inadequately supervised. The anonymous reporter could not be interviewed, and the investigation was unfounded.</p>			

Child No. 37	DOB February 2006	DOD July 2006	Accident
Age at death: 5 months old Substance exposed: Yes, cocaine			

Cause of death:	Multiple injuries sustained while a passenger in an automobile that struck a fixed object
Reason For Review:	Open intact family case at time of infant's death
Action Taken:	Investigatory review of records
<u>Narrative:</u>	Five-month-old infant was injured in an automobile accident with her 37-year-old mother. The mother had been driving in the rain and the car slid, swerved off the road and hit a tree. Four days later, the infant died in the hospital from her injuries. Four other children, two of the mother's and two grandchildren, survived the accident. A DCP investigation of the infant's death was unfounded. The infant was strapped into a car seat that was secured in the automobile by a seat belt. The mother was drug tested after the accident, and her urine tested negative for cocaine, but positive for amphetamines. The mother showed the investigator a bottle of diet pills that she had been taking, and investigation revealed that the diet pills were amphetamines.
<u>Prior History:</u>	The deceased was the mother's eighth child. She was born substance-exposed. The mother was indicated for substance misuse, and an intact family case was opened. The worker had been trying to get the mother to undergo a substance abuse assessment, but the mother had missed several appointments. The mother was caring for the deceased and her 4- and 5-year-old siblings. Two of her children were grown and three others were in the guardianship of their grandmother. During her weekly visits, the worker never observed the mother under the influence of drugs. The infant was current on her immunizations, and she and her 4- and 5-year-old siblings appeared well-cared for during the worker's visits. The mother had the support of her adult son. The intact family case remained open until April 2007.

Child No. 38	DOB January 2006	DOD July 2006	Accident
Age at death:	6 months old		
Substance exposed:	No		
Cause of death:	Asphyxia due to uncertain etiology		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u>	Six-month-old infant was found unresponsive when she was checked on by her mother in the night. The infant was found with a heavy blanket over her face, and she had been sleeping on a small couch with three other children. She was transported by ambulance to the hospital where she was pronounced dead.		
<u>Prior History:</u>	The 33-year-old mother has four surviving children ages 12, 10, 7, and 3. Their biological father is non-involved. The deceased's father is involved with the family. The family has a history with DCFS dating to October 2003 when the mother was indicated for burns by neglect to her oldest son. The boy burned himself while around a leaf fire while the mother was not properly supervising him. The mother was offered services, but she refused them. She was indicated for environmental neglect two months later because of the poor condition of her home. A referral was made to a family educator (to educate the mother about cleanliness issues). An environmental neglect report in September 2005 was unfounded because while the family's home was unfit to live in, the children were staying with a grandmother until the situation could be resolved. An inadequate supervision report in January 2006 was unfounded as well. The mother was not home to receive her 10-year-old son from school because she did not realize the child had begun full days from a ½ day schedule. Following the infant's death, the family moved to Tennessee.		

Child No. 39	DOB April 2006	DOD July 2006	Accident
Age at death:	3 months old		
Substance exposed:	No, but mother has a history of cocaine use		
Cause of death:	Suffocation		
Reason For Review:	Unfounded DCP investigation within a year of infant's death		

Action Taken: Investigatory review of records

Narrative: While high on cocaine, a 26-year-old mother held a pillow and her baby up to her and squeezed, hugging the infant. The baby's face was in the pillow, and he suffocated. The mother said she did not know why she did that, other than that she was high on cocaine. The mother pled guilty to child endangerment and was sentenced to 8 years in prison.

Prior History: The mother has a history with DCFS dating to 1997 when she gave birth to her second child, who was born substance-exposed. The maternal grandmother adopted the child and his 4-year-old sister in 1999. A third child born in 1998 has been in the custody of her mother since birth, but was cared for primarily by her grandmother. A fourth child, born in 2000 has been in the care of his father since birth. In June 2006, police called the hotline with a report of substantial risk of physical injury and environmental neglect to the deceased by his mother. The mother, her 33-year-old boyfriend, and the infant were staying in the home of a family friend when the boyfriend was arrested there for possession of a controlled substance. The investigation was unfounded because the mother denied knowing her boyfriend was in the possession of cocaine, the family friend reported the mother was a good mother, the infant was receiving proper medical care, and the home appeared safe. The investigator noted that the mother had no prior DCFS involvement, but failed to conduct a data check that revealed her prior history. The investigator was disciplined for this failure, and a memo was sent to staff in the office reminding them of the requirement.

Child No. 40	DOB May 1992	DOD July 2006	Accident
Age at death:	14 years old		
Substance exposed:	No		
Cause of death:	Drowning		
Reason For Review:	Teenager was a ward		
Action Taken:	Preliminary investigation		
Narrative: Fourteen-year-old ward went swimming with his 9-year-old nephew and a friend at an apartment complex swimming pool. He dove into the pool in five feet deep water and hit his head on the bottom of the pool. When his nephew did not see him come up, the nephew alerted a lifeguard who assumed the kids were playing. The nephew and the friend then pulled the ward up and out of the water, and another lifeguard began CPR. An ambulance was called, and the ward was taken to the hospital where he was pronounced dead.			
Prior History: The deceased was one of 13 siblings. He and the younger siblings entered foster care in 1996 after their mother gave birth to her fourth substance-exposed infant. At the time of his death, the ward and a 16-year-old sibling were living with their 30-year-old brother, his wife, and their 5 children. All of the younger siblings are in the care of older siblings with goals of subsidized guardianship either accomplished or pending.			

Child No. 41	DOB January 2006	DOD July 2006	Accident
Age at death:	6-1/2 months old		
Substance exposed:	No		
Cause of death:	Heat stress		
Reason For Review:	Unfounded DCP		
Action Taken:	Investigatory review of records		
Narrative: Six-and-a-half-month-old infant was found unresponsive in the afternoon by her great-grandfather. The infant was transported by ambulance to the hospital where she was pronounced dead. The infant's skin temperature at the hospital was 102.1 degrees. The infant and her 15-year-old mother had been staying at the great-grandfather's home because he had air conditioning. Temperatures had been in the 80s and 90s with high humidity for a week. In the morning on the day the infant died, the great-grandfather's air conditioner broke.			

Prior History: In June 2006, the hotline was called with concerns that the teenage mother was not making adequate plans for the infant when she went out. According to the reporter, the 15-year-old mother, who was staying with a family friend, would leave the home without taking the baby and would not return for hours. The 15-year-old returned to her own home during the investigation. The investigation was unfounded. The maternal grandmother, the infant's father, and a maternal aunt and uncle all reported that the infant was never left unsupervised, and the mother had a strong support system which helped her care for the infant. The investigator referred the mother to a teen parenting program.

Child No. 42	DOB February 2005	DOD August 2006	Accident
Age at death:	1-1/2 years old		
Substance exposed:	Yes, cocaine		
Cause of death:	Multiple injuries due to automobile striking pedestrian		
Reason For Review:	Open intact family case at time of infant's death		
Action Taken:	Investigatory review of records		
Narrative: One-and-a-half-year-old child was accidentally run over by a car driven by her paternal aunt. The aunt was talking to family members and driving away when she heard a "thump" under her car. The child's 44-year-old father was in the backyard at the time and her 38-year-old mother was in the hospital giving birth to her twelfth child. The new baby was the third of the mother's twelve children to be born substance-exposed.			
Prior History: The family has a history with DCFS dating to 2000 when the mother gave birth to her first substance-exposed infant. An intact family case was open for 14 months and the mother participated in substance abuse treatment. When the deceased was born substance-exposed in February 2005, the mother reported that she used cocaine after the father recently lost his job. The intact family case was reopened. The mother kept putting off substance abuse treatment because of things coming up with her children. The worker monitored the family with frequent visits, and the mother and father were said to be meeting minimum parenting standards. After the death of her child and the birth of her baby, the mother completed substance abuse treatment, and the intact family case was closed in June 2007.			

Child No. 43	DOB July 2006	DOD August 2006	Accident
Age at death:	1-1/2 months old		
Substance exposed:	No		
Cause of death:	Overlaying		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
Narrative: One-and-a-half-month-old infant was laid over while sleeping on a mattress on the floor with her nineteen-year-old mother and 12-month-old sibling. The mother was unfounded for death by neglect to the deceased and substantial risk of physical injury to her 12-month-old because the death was considered an accident. The surviving child went to live with his father following his sibling's death. The maternal grandparents were indicated for environmental neglect because the home that the mother, her children, and her siblings were living in was deemed uninhabitable by the local building department. The family was linked to community services for shelter while the home was repaired.			
Prior History: In April 2006, the Department investigated a report of abuse to the mother's 14-year-old sister. The sister had scratches on her face which she said she obtained in a fight with her 37-year-old mother. The report was unfounded following interviews with the 14-year-old, her mother, and school personnel. All agreed that the scratches on the girl's face were from her mother's attempts to defend herself against the girl. The investigator tried several times to interview family members in the home, but his attempts were unsuccessful.			

Child No. 44	DOB February 2004	DOD September 2006	Accident
Age at death:	2-1/2 years old		
Substance exposed:	No		
Cause of death:	Multiple injuries due to fall from height		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u> Two-and-a-half-year-old child died after he either fell or jumped from his twelfth floor window. At approximately 9:30 a.m., the child's 4-1/2-year-old sibling went into her mother's bedroom and told her mother and boyfriend that her brother went out the window. Investigation revealed that the mother had placed a dresser in front of the window in an attempt to prevent the children from having access to it. The child placed a toy box in front of the dresser, climbed on top of the dresser, and opened the sliding window. The window did not have a lock on it, and the child either fell or jumped out of the window. The family had only been living in the apartment for one month. The mother and her boyfriend were indicated for death by neglect and substantial risk of physical injury. After the child's death, the mother and her daughter went to live with the maternal grandparents, and an intact family case was opened. The case was closed four months later because of the mother's non-participation. She was provided with community referrals and continued to receive support from the maternal grandparents.			
<u>Prior History:</u> In December 2005, the hotline took a report of a bruise to the 1-1/2-year-old by his mother's boyfriend and a report alleging sexual molestation of the 4-year-old by her mother's boyfriend's brother. The children's great-grandmother had contacted the police with a report of possible sexual abuse to her great-granddaughter, and the hotline was notified. The children were seen in the emergency room, and the girl had a normal physical exam. The doctor determined that the mark on the 1-1/2-year-old boy's arm was an old burn, consistent with the mother's explanation of a burn from a heater. The great-grandmother agreed this was how the child was injured, and she had not been concerned about it. The police closed their case after they could not locate the family to interview the 4-year-old child. The Department located the family a month after the hotline report, and the 4-year-old denied being touched by her mother's boyfriend's brother. The brother did not have a criminal history, and he had limited contact with the child. Both reports were unfounded.			

Child No. 45	DOB March 2004	DOD September 2006	Accident
Age at death:	2-1/2 years old		
Substance exposed:	Unknown, but he was exposed at some point to methamphetamines		
Cause of death:	Acute craniocerebral trauma		
Reason For Review:	Child was a ward, and unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation pending		
<u>Narrative:</u> Thirty-nine-year-old foster mother reported that the deceased vomited, she changed him, and she went downstairs to drop off the dirty clothes and get a day care child up from his nap. She said she forgot to latch the safety gate at the top of the stairs, and the deceased fell down the stairs. After she heard the child fall, she went and picked him up, and he went limp in her arms. The foster father was not home at the time. The foster mother called 911. Paramedics responded and decided to call for a helicopter to take the child to the hospital (the family lived in a rural area). The child had severe head trauma and retinal hemorrhaging. An emergency craniotomy was performed, but the child died in surgery. The foster mother was indicated for death by neglect and inadequate supervision, and the indications were upheld on appeal. The deceased's younger sibling was removed from the home, and has since been returned home to her father. In addition to being a foster parent, the foster mother ran a daycare out of her home. The Department is seeking to revoke both licenses.			

Prior History: The deceased and his younger sibling were removed from their mother's care in August 2005 because of neglect arising from the mother's methamphetamine use. The children were placed together in the traditional foster home where the child died. In August 2006, the hotline was called by a service provider with allegations of suspicious bruising to the deceased by his foster mother. The investigation was unfounded because one of the marks reported was not a bruise, but a discoloration that had been present since entering foster care.

Child No. 46	DOB June 2006	DOD October 2006	Accident
Age at death: 3 months old Substance exposed: No Cause of death: Overlay Reason For Review: Indicated DCP investigation within a year of infant's death Action Taken: Full investigation pending for inclusion in a cluster report			
Narrative: Three-month-old infant was found unresponsive, face down, by his 35-year-old mother and 43-year-old father in the morning in the queen-sized bed they shared with the baby. After it was determined that the baby was overlaid, the Department conducted an investigation for death by neglect. It was unfounded. The mother reported that while she had a crib for the baby, he was irritable that night so he slept with her.			
Prior History: Between the two of them the parents have eleven children. The mother's three oldest children entered foster care in 1991 for abuse. They were placed with a paternal relative who was granted subsidized guardianship of them in 1998. In June 2006 the father's 1- and 7-year-old children were visiting him when he brought the 1-year-old to the hospital with first and second degree burns to his face, neck, and upper arm. The father reported that while he was cooking, the children were playing near the stove, and the 7-year-old knocked over a pan with hot grease, spilling it onto the 1-year-old. DCP investigated, indicating an allegation of inadequate supervision against the father, but unbounding an allegation of burns by neglect because the attending physician opined that the injuries were consistent with the father's explanation, the father sought prompt medical care for the child, he was cooperative, and he appeared concerned.			

Child No. 47	DOB July 2006	DOD October 2006	Accident
Age at death: 2 months old Substance exposed: No Cause of death: Positional asphyxia Reason For Review: Open intact family case at time of infant's death Action Taken: Full investigation pending for inclusion in a cluster report			
Narrative: Two-month-old infant was found deceased by her 20-year-old mother. The infant had been sleeping face down in an adult bed with her mother. A DCP investigation following the infant's death revealed that the mother had smoked some marijuana and drank a wine cooler prior to sleeping with the infant. Her 33-year-old husband was an over the road truck driver and was not home at the time of the infant's death. The infant had a crib, but it was filled with a bag of clothes. The mother reported that the infant was fussy and hated to sleep on her back, so she put her on her stomach in bed with the mother. The mother was indicated for death by neglect to the infant and substantial risk of physical injury to her two surviving children, ages 1 and 2, because she had been educated numerous times about sleep safety for babies.			

Prior History: Six weeks before the infant's death, a relative called the hotline to report that the mother was using drugs and was the sole caretaker for her three children while her husband was away during the week. The husband just found out that he was not the father of the infant, and the father was believed to be the mother's drug dealer. The mother was afraid that her husband might hurt the baby. The husband was indicated for risk to the infant and the mother was indicated for risk to all three children because the parents were under a great deal of stress in that the mother had a history of drug use, she was recently diagnosed with cancer, the husband was not the father of the baby, and the mother was caring for three children aged 2 and under while her husband was on the road. An intact family case was opened, and the worker was attempting to engage the family in services at the time of the infant's death. The intact family case remains open.

Child No. 48	DOB May 2001	DOD October 2006	Accident
Age at death: 5 years old			
Substance exposed: No			
Cause of death: Multiple injuries sustained as a pedestrian due to van striking pedestrian			
Reason For Review: Unfounded DCP investigation within a year of child's death			
Action Taken: Investigatory review of records			
Narrative: Five-year-old boy was hit and run over by a hit-and-run driver. The boy's mom had dropped him off earlier in the day at his aunt's home to play with his cousins. She was picking him up at the time of the incident. The boy was walking with his aunt when he ran across the street toward his mother and was hit by a van that ran a stop sign. The van slowed down after hitting and running the boy over, but then drove away. A police investigation remains open.			
Prior History: In May 2006, the hotline was called, allegedly by a neighbor, with a report of sexual abuse to the boy by his grandmother. The reporter said the mother was aware of the abuse and allowed the grandmother to continue to have access to the child. The report was unfounded after the grandmother, mother, and boy all denied the allegation and the neighbor denied ever calling the hotline. The report appeared to have been falsely made.			

Child No. 49	DOB September 2006	DOD November 2006	Accident
Age at death: 2 months old			
Substance exposed: No			
Cause of death: Positional asphyxia			
Reason For Review: Unfounded DCP investigation within a year of infant's death			
Action Taken: Full investigation pending for inclusion in a cluster report			
Narrative: Two-month-old infant was sleeping with her 24-year-old mother on a couch. The infant was sleeping on her mother's stomach and was a little fussy when they first laid down to sleep around 10:00 pm. The mother awoke in the early morning and found the infant unresponsive between the mother's body and the back of the couch. She called 911, and the infant was pronounced dead at the scene. The mother tested negative for alcohol and drugs in her system. The Department unfounded the mother for death by neglect.			

Prior History: The mother is a former ward, whose oldest child, now 7, went into foster care in 2003 for 1-1/2 years because of neglect. In August 2006, the Department investigated a report of medical neglect to the mother's 1-1/2-year-old child. The mother contacted her child's physician asking what to do about a burn from food. The mother was evasive at first, but finally gave her name and agreed to bring the child into the office, but then never showed up. An investigator went to the family's home and instructed the mother to take the child to see the doctor. The mother reported that she hadn't taken the child to the doctor since her call the day before because she did not have transportation. The child was seen by her primary care physician and evaluated by an expert in child abuse and neglect. She was prescribed some ointment. Both doctors opined that the child's burns on her lip, chin, and chest were consistent with the explanation that she pulled a bowl of hot soup down on herself. The mother had placed the bowl on the kitchen table to cool. The investigation was unfounded because the two doctors did not believe the child was medically neglected, the mother had sought help immediately from her neighbor, and she had called her doctor's office for advice.

Child No. 50	DOB November 2001	DOD November 2006	Accident
Child No. 51	DOB April 1990	DOD November 2006	Accident
Age at death: 5 years old & 16 years old			
Substance exposed: No			
Cause of death: Asphyxia due to residence fire			
Reason For Review: Pending DCP investigation at time of children's death			
Action Taken: Investigatory review of records			
Narrative: Five and 16-year-old unrelated children died in a morning trailer fire. The 16-year-old child's mother also died in the fire, an 8-year-old sibling survived. The 5-year-old child's 6-year-old sibling and mother survived the fire. Two adults were injured trying to rescue the victims. Three children were staying with their father and were not home at the time of the fire. The Fire Department believed the point of ignition of the fire was a wood stove in the trailer.			
Prior History: A brother and sister lived in the trailer with their families. The brother's family consisted of himself, his 8-year-old son, his girlfriend, and her five children (one of whom was the 5-year-old who died in the fire). The girlfriend was indicated for neglect in 1993 and 1998. Her ex-husband was indicated in 2005 for sexually abusing her two daughters from a previous relationship. An intact family case was open for a brief time, but the girlfriend did not follow through on counseling for the girls and withdrew from services. The sister's family consisted of herself, her boyfriend, and her 16-year-old son. She and her son had been involved with DCFS on and off since 1991. At the time of the fire, there was a pending DCP investigation of sexual acting out between the 13-year-old girl (who had previously been sexually abused) and her 8-year-old brother. The 13-year-old went to stay with her grandfather during the investigation. A home safety checklist was completed prior to the fire. The investigator noted that the home had a wood-burning stove in an add-on room of the trailer and that the room had a smoke detector. Two days prior to the fire, police called the hotline to inform the Department that the 13-year-old and her 11-year-old sister reported recent sexual abuse by their uncle. Police were trying to determine whether the uncle was a caretaker, which would necessitate investigation by DCFS. Following the fire, protective custody was taken of the five surviving children. The court released three of the children to their father and granted guardianship of the other two to relatives.			

Child No. 52	DOB September 2006	DOD November 2006	Accident
Age at death: 2-1/2 months old			
Substance exposed: No			
Cause of death: Asphyxia due to undetermined etiology			
Reason For Review: Indicated DCP investigation within a year of child's death			
Action Taken: Investigatory review of records			

Narrative: Almost three-month-old infant was found unresponsive face down in a comforter in his bassinet by his 21-year-old mother. The infant had been placed to sleep on his side. Contrary to infant sleep recommendations, there were a few blankets and a comforter in the bassinet. A DCP investigation of the infant's death was unfounded. The mother was devastated by the infant's death, and family members and the child's pediatrician reported that the mother took good care of the deceased and his 11-month-old brother. An intact family case was opened for a short time following the infant's death.

Prior History: In February 2006, the hotline was called with allegations of substantial risk of physical injury to the deceased's then 3-month-old sibling when the mother called the police to report that during an argument her 21-year-old boyfriend pushed her while she was holding her baby. The report was unfounded against the boyfriend because the violence was not directed toward the baby and the boyfriend neither lived in the home nor was in a caretaker role. The mother reported that she was not going to see the boyfriend anymore and that she would get an order of protection. In March 2006 the hotline was called again after the mother called police to report that the boyfriend again pushed her while she was holding the baby, and beat her up after she put the baby down. The boyfriend was indicated for substantial risk of physical injury after it was determined that the mother had moved, but the boyfriend found her. A warrant was issued for his arrest. The mother obtained an order of protection.

Child No. 53	DOB October 2006	DOD December 2006	Accident
Age at death: 2 months old Substance exposed: No Cause of death: Asphyxia due to probable overlay Reason For Review: Unfounded DCP investigation within a year of child's death Action Taken: Full investigation pending for inclusion in a cluster report			
Narrative: Two-month-old infant was found unresponsive by her parents in the morning. She had been put to sleep between her parents in a full-sized bed. The 33-year-old woman, who is reportedly large, and the 41-year-old father had been drinking the previous night. The father was reportedly still intoxicated in the morning. The infant typically slept with her parents, despite there being a crib and bassinette in the home. The crib was stacked with clothing. Allegations of death by neglect and substantial risk of physical injury to the infant's surviving siblings were unfounded. Services were offered to the family, but they refused them.			
Prior History: The mother had been in the custody of DCFS for two years as a teenager because of sexual abuse to her sister by her mother's boyfriend. In December 2003, the mother was indicated for substantial risk of sexual injury to her 2 daughters for allowing them to reside in her mother's home with the perpetrator. The investigator referred the mother to a social services agency to help her find housing, and the boyfriend agreed to stay out of the home until the mother and children moved. In August 2005, the mother called the hotline requesting housing assistance for herself, her 2-month, 1, 13, and 16-year-old children, and a referral was made. In November 2006, an anonymous reporter called the hotline to report sexual abuse of the 2-year-old by the infant's father. The report was unfounded. There was no physical evidence of sexual abuse, both the mother and infant's father denied it, and the child's own father said the report probably would not have been made if the mother allowed him to see his child.			

Child No. 54	DOB October 2002	DOD January 2007	Accident
Child No. 55	DOB September 2004	DOD January 2007	Accident
Age at death: 4 years old and 2 years old Substance exposed: No Cause of death: Carbon monoxide intoxication due to inhalation of smoke and soot from trailer house fire Reason For Review: Unfounded DCP investigation within a year of children's death Action Taken: Investigatory review of records			

Narrative: Four and two-year-old brothers were killed in a trailer house fire. The 4-year-old boy's twin brother survived. He reported that his younger brother had been playing with the stove just before the fire. The 2-year-old had been reprimanded on prior occasions for playing with the stove's burner knobs. The fire occurred at close to 10:00 am while the three adults in the home, including the boys' mother, were sleeping. The owner of the home said there were two smoke detectors in the trailer. The Department investigated the boys' deaths. The 24-year-old mother was indicated for death by neglect to the two boys and for substantial risk of physical injury to her surviving child. The surviving boy was placed with his grandfather and step-grandmother in a neighboring state, and they obtained guardianship of him.

Prior History: In September 2006, a neighboring state called the hotline to report that the mother and 2-year-old were living in Illinois in a home without food or water, that the boy had never been to a doctor and had no immunizations, and that the mother was a substance abuser who could not care for the child. The twins were reported to be living in the neighboring state with relatives. A report was taken for investigation of inadequate food and substantial risk of physical injury. The investigation was unfounded because the investigator observed the home where the mother and son were living (not the same home in which the fire later occurred) and it had running water and operable utilities, there was an adequate supply of food in the home, the child had been seen at the county health department and had received immunizations, and the mother did not appear to have a substance abuse problem. The mother was trying to get settled in Illinois so that the twins could join her.

Child No. 56	DOB September 1986	DOD January 2007	Accident
Age at death: 20 years old Cause of death: Blunt trauma to head and neck County: Cook Reason For Review: Deceased was a ward Action Taken: Full investigation pending for inclusion in a cluster report			
Narrative: Twenty-year-old severely developmentally disabled ward was at his vocational training center working on a loading dock placing cardboard boxes in a compressor recycling machine. The ward placed his head inside the machine as the compacting plate was rising, and his head was crushed. The ward had worked at the center since May 2006. The Illinois Department of Human Services investigated the incident and found the training center negligent.			
Prior History: The ward entered foster care in 1988 because of neglect. He lived with the same foster parent for 18 years. Although she did not wish to adopt the ward, she was committed to becoming his guardian once the Department's guardianship ended (automatically at age 18). At the time of his death, the ward was without a guardian.			

Child No. 57	DOB April 1990	DOD February 2007	Accident
Age at death: 16 years old Substance exposed: No Cause of death: Multiple blunt force trauma due to automobile accident Reason For Review: Indicated DCP investigation within a year of teenager's death Action Taken: Investigatory review of records			
Narrative: Sixteen-year-old girl was one of four teenagers who died when a car struck a utility pole about 2:30 am on a Sunday. Five other young people were injured. All nine people, eight of them teenagers, left a party and were riding in a four-door sedan when the car struck the pole. One of the injured five was a DCFS ward who later died. The 23-year-old woman driver was charged with reckless homicide and aggravated drunk driving. She has pleaded not guilty and is awaiting trial. Three of the teenagers, including the deceased, tested positive for alcohol.			

Prior History: In August 2006, the hotline was contacted with a report of substantial risk of physical injury and inadequate supervision to the deceased and her 7-year-old sister by their 40-year-old mother. The mother, who had an order of protection for herself and the girls against the 41-year-old father, left the children with the father and moved to California. She did not leave any forwarding information and had not been in contact with the girls. The father sent the children to live with his mother so he wouldn't violate the order of protection. A relative contacted the police for the girls because they wanted the order lifted so they could live with their father. The order of protection was eventually quashed, and the children went to live with their father.

Child No. 58	DOB October 2006	DOD February 2007	Accident
Age at death:	3-1/2 months old		
Substance exposed:	No, but the mother has a history of alcohol abuse		
Cause of death:	Overlay		
Reason For Review:	Indicated DCP investigation within a year of infant's death		
Action Taken:	Full investigation pending for inclusion in a cluster report		
Narrative: Three-and-a-half-month-old infant was found unresponsive in the morning by her 25-year-old mother. The mother and infant had slept at a friend's home and were sharing a bed. The friend called 911 and administered CPR as instructed. An ambulance took the infant to the hospital where she was pronounced dead. The mother was indicated for death by neglect.			
Prior History: A month earlier, in January 2007, law enforcement called the hotline after responding to a call that the mother was intoxicated and the 27-year-old father found the mother sitting on the baby's head on the couch. The father had pulled the mother off the baby and called 911. The baby was taken to the hospital where she was found to have no visible signs of injury. The mother was indicated for substantial risk of physical injury to the baby. The investigation was closed eight days prior to the infant's death with a referral to an alcohol treatment program for the mother. The father was supposed to take care of the infant if the mother was intoxicated.			

Child No. 59	DOB March 1992	DOD February 2007	Accident
Age at death:	14 years old		
Substance exposed:	No		
Cause of death:	Multiple injuries due to automobile accident		
Reason For Review:	Ward; pending DCP investigation at time of teenager's death		
Action Taken:	Investigatory review of records		
Narrative: Fourteen-year-old ward died eight days after suffering multiple injuries in an automobile accident. The boy was one of nine people, eight of them teenagers, who had left a party and were riding in a four-door sedan when it struck a utility pole about 2:30 a.m. on a Sunday. Four teenagers died at the scene. The 23-year-old woman driver was charged with reckless homicide and aggravated drunk driving. She has pleaded not guilty and is awaiting trial.			
Prior History: The deceased's family has a history with DCFS dating to 2002 when a medically complex older step-brother was removed from the home for medical neglect. The deceased and a younger half-sibling were removed from the home in 2003 following the death of their 10-month-old brother who fell head first into an industrial-sized mop bucket. The deceased had multiple placements and a history of running away. In 2006, the child was placed in a specialized foster home with a woman he grew to call mom. He was doing well in the placement, but he failed to go home every night. In January 2007, the hotline was called with a report of inadequate supervision by the foster parent because she failed to report the child missing after he had not returned home in three days. The child died while that investigation was pending. The foster mother was subsequently indicated for inadequate supervision; the investigator found that even after being reminded that she had to call the police every time the child failed to come home, she had not called the night of the car crash.			

Child No. 60	DOB May 1986	DOD March 2007	Accident
Age at death:	20 years old		
Substance exposed:	No		
Cause of death:	Multiple blunt force injuries		
Reason For Review:	Deceased was a ward		
Action Taken:	Full investigation pending for inclusion in a cluster report		
<u>Narrative:</u> Twenty-year-old ward was on a weekend visit to his 45-year-old mother's home when he was hit and killed by a train. The ward had been waiting for a westbound train to clear the roadway. The crossing gates were down. When the westbound train passed, he walked north across the tracks and was hit by an eastbound train. The accident happened in the afternoon, and the ward was not under the influence of any drugs or alcohol.			
<u>Prior History:</u> The ward's family has a history with DCFS dating to 1991 because of neglect. He and the three youngest of his five siblings entered foster care in 1998. The ward had lived at a transitional living program since June 2005. Just prior to his death he was accepted into a Department of Human Services for the Developmentally Disabled (DHSDD) placement, and he was waiting for a transfer date.			

Child No. 61	DOB March 2002	DOD March 2007	Accident
Age at death:	9 days shy of 5 years old		
Substance exposed:	No		
Cause of death:	Carbon monoxide intoxication due to smoke and soot inhalation from house fire		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation, no report issued		
<u>Narrative:</u> Five-year-old child and his 70-year-old maternal grandfather were found by the local fire department inside the grandfather's home inches from the front door, which had an inner security gate. The grandfather had the key to the gate in his hand. The mother frequently allowed the child to stay with his grandfather, and the pair reportedly were very close. The State Fire Marshall classified the cause of the fire as undetermined.			
<u>Prior History:</u> In April 2005 and May 2006, the grandfather called the hotline alleging sexual abuse to his grandson by his 31-year-old daughter's boyfriend. DCP investigations were conducted on both occasions and were unfounded because there was no evidence the child was sexually abused. The mother, boyfriend, and child all denied sexual abuse, and there was no physical evidence indicating the child had been abused.			

Child No. 62	DOB December 1989	DOD April 2007	Accident
Age at death:	17 years old		
Substance exposed:	No		
Cause of death:	Multiple injuries due to a fall from height		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u> Seventeen-year-old girl was on a rooftop and fell through a skylight three stories to the concrete floor. She was dead on the scene. Toxicology results from her autopsy revealed a high blood-alcohol level.			

Prior History: A month before her death, the teenager swallowed 17 sleeping pills and called a friend. The friend called 911, and the girl was hospitalized. The teenager reported that her stepfather grabbed her by the throat the day before and threw her down, and he had been beating her mother for years. The teenager had no injuries. The Department investigated and unfounded a report of substantial risk of physical injury to the teenager by her mother and stepfather. The stepfather reported that he came home to find the teenager smoking pot with her friends. He grabbed her to prevent her from leaving with them in a car. The mother admitted to a history of domestic violence with the step-father. The family's life was chaotic and the girl was depressed and acting out as a result. The family was referred to mental health and substance abuse services.

Child No. 63	DOB February 1999	DOD May 2007	Accident
Age at death: 8 years old			
Substance exposed: No			
Cause of death: Smothering asphyxia due to inability to extricate from prone position			
Reason For Review: Unfounded DCP investigation within a year of child's death			
Action Taken: Investigatory review of records			
Narrative: Eight-year-old medically complex child was found unresponsive in the morning by her 29-year-old mother. She was found on her stomach with her face blocked by the mattress. The child had spastic quadriplegia, a form of cerebral palsy, which left her unable to extricate herself from the position.			
Prior History: There were two prior unfounded reports involving the deceased. Both of the reports were made by school staff. In October 2006 the school reported that the child had a bruise on her face and on her knees, and they questioned how the injuries were caused given the child's limited movement. DCP investigated the report. The mother explained that the child was injured when she fell out of bed. The girl's 6- and 9-year-old brothers were home when the incident occurred and corroborated their mother's account. A 4-year-old sister was not home at the time. While the investigator was in the home, he witnessed the child almost scoot herself off of a couch. The child's doctor reported that the child could fall out of a bed and was likely to bruise easily given her medical issues. The parents were working with the Division of Specialized Care for Children to obtain a bed with rails for the child, and the investigator wrote a letter of support. In January 2007, the school called the hotline again to report the child was injured in her genital area. The child was taken to her doctor who diagnosed diaper rash. The doctor said the diaper rash could appear bad after just one diaper change; and the report was unfounded.			

Child No. 64	DOB January 2007	DOD June 2007	Accident
Age at death: 4-1/2 months old			
Substance exposed: Yes, marijuana			
Cause of death: Asphyxia due to uncertain etiology			
Reason For Review: Open intact family case at time of infant's death			
Action Taken: Investigatory review of records			
Narrative: Twenty-eight-year-old mother awoke in the morning to find her 4-1/2-month-old infant deceased. The mother had placed the infant to sleep face down on a couch cushion on the floor next to her. She had last seen him alive at 3:00 am when she fed him part of a bottle. The Department was not called to investigate the child's death.			

Prior History: In June 2002, an intact family case was opened on the mother and her 1-1/2- and 4-year-old children after the mother was indicated for inadequate supervision. The children's father was incarcerated for a drug offense. The family's case was closed in June 2003 when the mother, who was struggling with mental health and substance abuse issues, gave guardianship of the children to their paternal grandmother. In January 2007, the mother was indicated for substantial risk of physical injury after she and the deceased tested positive for marijuana at the infant's birth. The mother said she used marijuana to help with chronic pain from several medical issues. An intact family case was opened on the mother, 21-year-old father, and infant. The parents were prepared for the infant with appropriate baby items, including a bassinet. At the time of the infant's death, the mother had had a substance abuse assessment, and the worker was trying to get her into inpatient substance abuse treatment. The worker saw the family weekly.

Child No. 65	DOB August 1988	DOD June 2007	Accident
Age at death: 18 years old Substance exposed: No Cause of death: Multiple injuries sustained as a pedestrian struck by a van Reason For Review: Teenager was a ward Action Taken: Preliminary investigation			
Narrative: Eighteen-year-old ward was hit by a car around 11:45 p.m. at night as he was crossing the street with another DCFS ward to catch the train. He was on his way back to his placement after spending the afternoon and evening with his brother. The ward was not under the influence of any drugs or alcohol. Police have no leads in the ward's death. The surviving ward has received grief counseling.			
Prior History: The deceased was one of 12 children born to his parents. He and his siblings entered foster care in 2000 after they were discovered living with their mother in unsanitary conditions. The 34-year-old mother was indicated for environmental neglect, inadequate supervision and inadequate food. Later, she was indicated on sexual harm allegations when two of her children disclosed sexual abuse by two of her paramours. At the time of his death, the ward was living in Chicago in a transitional living program. He was self-reportedly gang-involved. He wished to be placed outside the city and was awaiting placement at a program in the suburbs.			

Child No. 66	DOB June 1998	DOD June 2007	Accident
Child No. 67	DOB March 2001	DOD June 2007	Accident
Age at death: 9 years old and 6 years old Substance exposed: No Cause of death: Asphyxia due to inhalation of products of combustion as a result of a house fire Reason For Review: Unfounded DCP investigation within a year of the children's deaths Action Taken: Full investigation pending			
Narrative: Nine- and six-year-old brothers, both of whom were autistic, were found by their 30-year-old mother earlier in the day playing with a lighter. The mother took the lighter away and placed it out of reach of the children. Later that day, the mother heard a cry for help. When she went to the boys' bedroom, the room was engulfed in flames. She got her 9-1/2-year-old daughter from her bedroom and out of the house. She tried to rescue the boys through a bedroom window, but she was unable to save them. An inspection of the home following the children's death revealed many lighters in several locations within reach of the children. A DCP investigation of the children's death was unfounded against the mother.			
Prior History: In December 2006, the mother called the hotline alleging that the father had spanked the boys while they were in his custody, and he left linear welts on their buttocks. A DCP investigator observed some marks on the older boy's buttocks, which the father said were from sliding down the stairs. During the course of the investigation the mother was granted full custody of the children, and the investigation was unfounded.			

Natural

Child No. 68	DOB June 2006	DOD July 2006	Natural
Age at death:	5 weeks old		
Substance exposed:	No, but mother has a history of heroin use		
Cause of death:	Sudden Infant Death Syndrome (SIDS)		
Reason For Review:	Infant was a ward		
Action Taken:	Investigatory review of records		
<u>Narrative:</u> Five-week-old ward was found unresponsive in her crib at around 3:30 in the morning by her foster mother. The infant had been seen at the doctor four days earlier for cold-like symptoms and was prescribed saline nasal spray.			
<u>Prior History:</u> The deceased had 3 half-siblings who are placed together in the foster home of a family friend and have permanency goals of guardianship. The children entered foster care in September 2002 after their mother hit the deceased's 5-year-old brother in the head, left inpatient drug treatment with the children, stopped taking her medication for depression, used heroin, and was living on the street with her children. After the children were removed from her care, the 33-year-old mother did not engage in treatment, but visited the children. The 45-year-old father, who also had a substance abuse problem, engaged in treatment and maintained sobriety for a year before relapsing. The father reengaged in treatment in February 2004, going into a recovery home. He also received vocational training and visited the children regularly. Workers hoped to return the children to their father, but he relapsed again in September 2005 and lost his job. He continued to reside at the recovery home and work on his substance abuse, but because of the length of time the children had been in care, the permanency goal for the children was changed. The mother was pregnant with the deceased in December 2005 when she was in a car accident that left her in a coma for several months. When the mother gave birth to the deceased, she had come out of the coma, but required 24-hour care, and the infant entered foster care.			

Child No. 69	DOB March 2003	DOD July 2006	Natural
Age at death:	13 years old		
Substance exposed:	No		
Cause of death:	Medulla blastoma		
Reason For Review:	Open preventive services case at time of child's death and unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u> Thirteen-year-old girl died in her home from brain cancer. Family members and hospice staff were present. The girl was diagnosed with the brain tumor in February 2005.			
<u>Prior History:</u> A preventive services case was opened in July 2005 following a referral for child welfare services. The referral source was concerned that the 34-year-old mother was under extreme stress because of her daughter's cancer diagnosis and treatment, and she was having difficulty parenting her youngest child, who had ADHD. The mother was grateful for the support. In October 2005, a hospital called the hotline alleging medical neglect to the child because her mother was a day late bringing her in for a blood transfusion. The single mother, who traveled 1-1/2 hours each way to the hospital and was also caring for her 8- and 16-year-old daughters, had called the child's oncologist who said it was okay to bring the girl in a day late. The investigation was unfounded. The Department provided the family with financial assistance, day care for the youngest girl, family therapy, and emotional support. Following the child's death, the case remained open until January 2007 to help the family with their grief.			

Child No. 70	DOB March 1995	DOD July 2006	Natural
Age at death:	11 years old		
Substance exposed:	No		
Cause of death:	Staphylococcal sepsis		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Full investigation, Report to Director 6/29/07		
<u>Narrative:</u>	Eleven-year-old severe insulin-dependent diabetic child was brought to the hospital in cardiac arrest by her mother and aunt. The child was diagnosed with a staph infection and later pronounced dead. Doctors reported that because the child's diabetes was not being regulated, her immune system may have been too weak to fight off the infection. During the four days prior to being taken to the hospital, the child's blood glucose levels were more than four times the normal range. The 41-year-old mother was indicated for medical neglect of the child. She was unfounded for neglect in the child's death because the hospital did not contact the hotline until fourteen days after the child's death, and having been given a choice by the hospital, the mother decided not to have an autopsy conducted. Doctors could not say for certain that the failure to properly treat the child's diabetes caused the child's death.		
<u>Prior History:</u>	The mother has a history of medically neglecting the child dating to 2003 when she was indicated for failing to consistently give the child her insulin shots, resulting in her hospitalization twice in one month. An intact family services case was opened for one year. Two months prior to the case closing, a second investigation was initiated against the mother for medical neglect. It was indicated eleven days after the intact family case was closed. Two years later, school personnel called the hotline to report that the child's diabetes was not being regulated. During the investigation, the child changed schools and the new school also called the hotline alleging that the child's glucose levels were not being regulated. The mother was indicated for medical neglect on both investigations. The mother agreed for the child to reside with the child's aunt, and the aunt was to pursue private guardianship. No case was opened to ensure the plan, and the aunt never sought private guardianship.		

Child No. 71	DOB December 1995	DOD July 2006	Natural
Age at death:	10 years old		
Substance exposed:	Yes, cocaine		
Cause of death:	Cerebral palsy		
Reason For Review:	Open intact family case within a year of child's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u>	Sixty-five-year-old father noticed that his 10-year-old child with cerebral palsy was having trouble breathing. He drove her to a clinic for medical attention, and personnel there called for an ambulance. The child was taken to the emergency room where she was pronounced dead. The child was the youngest of eight children born to her 42-year-old mother.		
<u>Prior History:</u>	The family has a history with DCFS dating to 1992 because of the mother's substance abuse. In 1997, four of the mother's eight children were adopted by their maternal grandmother. In April 2004, a physician called the hotline with allegations of inadequate food and medical neglect to the deceased by her mother and father. Both parents were indicated for malnutrition, and an intact family case was opened in September 2004 for neglect. The deceased lived with her father who cared for her with the assistance of her older siblings, and the child gained weight. The mother visited regularly. The intact family case was closed in March 2006.		

Child No. 72	DOB January 2005	DOD July 2006	Natural
Age at death:	1-1/2 years old		
Substance exposed:	No		
Cause of death:	Bronchopneumonia		
Reason For Review:	Pending DCP investigation at time of child's death		

Action Taken: Full investigation pending

Narrative: One-and-a-half-year-old child, who was born with multiple congenital abnormalities and who had diabetes, died in the emergency room after being brought there by her paternal grandmother who noticed she was having trouble breathing.

Prior History: Beginning when she was 6 months old, the child was the subject of four hotline reports alleging medical neglect by her 18-year-old mother. Her father was not involved in her care as he was incarcerated. Relatives made all four of the reports to the hotline. The first two investigations were unfounded. The third was indicated, but there was no follow-up because the investigator was under the misconception that the maternal grandmother had obtained private guardianship of the child. The fourth investigation was pending at the time of the child's death. Thirteen days earlier, the child's doctor called the hotline to report that the mother had missed medical appointments for the child. The following day, a relative called stating the child appeared very ill, but the mother did not take him to the doctor. An investigator saw the child the same day and instructed the mother to take him to the doctor. The child was seen in the emergency room and diagnosed with an ear infection. The mother was told to return four days later, but she missed the medical appointment and another scheduled for a week later. An anonymous reporter called the hotline the day before the child's death to report the mother missed the child's medical appointment that day and that the child appeared sick. The next day an investigator went to the home to check on the child and was told he had died early that morning. The mother was ultimately indicated for medical neglect, and an intact family case was opened for a short time to monitor the mother with her second child, a healthy 2-month old girl.

Child No. 73	DOB January 2006	DOD July 2006	Natural
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Age at death:	6-1/2 months old
Substance exposed:	No
Cause of death:	Sudden Infant Death Syndrome (SIDS)
Reason For Review:	Pending DCP investigation at time of infant's death
Action Taken:	Investigatory review of records

Narrative: Six-and-a-half-month-old infant was found unresponsive in the morning by her 26-year-old mother. The infant had been sleeping face up on a loveseat. The infant's 28-year-old father and 5 and 10-year-old siblings were also in the home when the infant was found deceased. The infant was the second of the mother's children to die. In November 2000 the mother awoke to find her 4-month-old daughter unresponsive. That child's cause of death was interstitial pneumonitis. A DCP investigation of the second child's death was unfounded for neglect.

Prior History: The mother's two older children entered foster care in June 2003 because of a domestic violence incident between the mother and the infant's father. The boys were returned to the mother's custody in May 2004, and guardianship was returned to her in August 2005. The DCFS case was closed in October 2005. In June 2006 an anonymous neighbor called the hotline with an allegation of inadequate supervision to the boys, stating that they were constantly unsupervised late at night by the parents, and the parents were always partying with loud music and drugs. The investigation was pending at the time of the infant's death, and it was subsequently unfounded. Before the child died, the investigator had interviewed the parents, children, and maternal grandmother who all denied the children were ever unsupervised. The investigator also spoke with the landlord, the father's probation officer, and the children's doctor. The investigator had completed a home safety checklist and substance abuse screens, and taken the parents for random urine screens, which were negative.

Child No. 74	DOB July 2006	DOD July 2006	Natural
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Age at death:	0
Substance exposed:	Unknown, screen unable to be completed
Cause of death:	Extreme prematurity
Reason For Review:	Open intact family case at time of infant's death

Action Taken: Investigatory review of records
Narrative: Infant, born prematurely at 23-24 weeks gestation and weighing only 1 pound, died shortly after birth. A drug screen on the 23-year-old mother was negative. A drug screen on the infant could not be completed.
Prior History: The infant was the mother's fourth child. She gave her third child up for adoption. The deceased's 26-year-old father is also the father of the second child. The mother has a history of neglecting her children dating to 2002. An intact family case was opened in January 2006 after allegations were made of domestic violence and drug abuse by both parents. After two more investigations, the failure of the parents to participate in services, and the birth/death of the deceased, the worker screened the family's case with the State's Attorney's Office requesting court involvement. The request was denied. Eight months and two investigations later, the Department took protective custody of the 4- and 9-year-old children. They were placed in the care of a paternal aunt where they remain.

Child No. 75	DOB July 2006	DOD August 2006	Natural
Age at death:	Almost one month old		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome (SIDS)		
Reason For Review:	Unfounded DCP Investigation within a year of child's death		
Action Taken:	Investigatory review of records		
Narrative: Almost one-month-old infant was found unresponsive by his parents in the morning. There was a bassinette in the home, but the infant had been sleeping with his parents in an adult bed.			
Prior History: In April 2006, prior to the birth of the deceased, the hotline was called with a report of inadequate supervision to the deceased's 2-year-old half-brother. Some high school students called police to report that a small child was outside alone with blood on his hands and face. Paramedics quickly determined that the blood was actually Jello, and within 4-5 minutes of the arrival of police, the father came looking for the child. The investigation was unfounded. The child, who is in the guardianship of his paternal grandparents because his mother is out of state and his father is a long-haul truck driver, opened the door and went outside while his father was in the bathroom. He wandered down the block. This was the first time the child had done this. The family immediately installed a door knob protector and a hook on the screen door out of the child's reach, so he could not get out alone again.			

Child No. 76	DOB February 2006	DOD August 2006	Natural
Age at death:	6 months old		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome (SIDS)		
Reason For Review:	Pending DCP investigation and open intact family case within a year of child's death		
Action Taken:	Investigatory review of records		
Narrative: Six-month-old infant was found unresponsive next to her mother in bed. She was taken by ambulance to the hospital where she was pronounced dead.			
Prior History: The deceased was the youngest of four children born to her 29-year-old mother and 38-year-old father. The mother also has two children from a prior relationship, who live with their maternal grandmother pursuant to a private agreement. An intact family case was opened on the family in January 2004 after the mother was observed at a McDonald's under the influence of drugs and unable to properly care for her children. The case remained open until October 2005. Services focused on substance abuse treatment for the mother and stabilization of the family's living situation. The father got a job, the family found housing, the children were enrolled in school, and the mother engaged in a methadone maintenance program. In June 2006 the hotline was contacted by an anonymous reporter who alleged environmental neglect, inadequate food, and drug use by the parents. This investigation was pending at the time of the infant's death and was subsequently unfounded.			

Child No. 77	DOB August 2006	DOD August 2006	Natural
Age at death:	0		
Substance exposed:	No		
Cause of death:	Extreme prematurity		
Reason For Review:	Infant was the child of a ward		
Action Taken:	Preliminary investigation		
<u>Narrative:</u> Sixteen-year-old ward gave birth to a premature infant while she was on run from her placement. The baby only lived for a few hours. The ward's worker did not know that she was pregnant. After the death of the baby, the ward called a funeral home to come pick up the baby and then left the hospital against medical advice. The ward's worker assisted the maternal grandmother in making arrangements for the baby's burial. The mother resurfaced in January 2007, and she is currently in a transitional living program.			
<u>Prior History:</u> The 16-year-old has been a ward since 2001 because of physical and sexual abuse while in the care of her mother. The ward had been on run since January 2006. Her worker followed the Department's policy regarding children on run and had been working with the child's guardian ad litem to try and locate her.			

Child No. 78	DOB December 2005	DOD August 2006	Natural
Age at death:	1-1/2 years old		
Substance exposed:	No		
Cause of death:	Anoxic encephalopathy due to acute loss of airway from mucous plug of tracheotomy		
Reason For Review:	Pending DCP investigation and open intact family case at time of child's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u> One-and-a-half-year-old medically complex child died while hospitalized. The child coughed causing a mucous plug in her tracheotomy which left her without oxygen for approximately 10 minutes. As a result, she was brain damaged and unable to breathe on her own, and the mother decided to withdraw life support.			
<u>Prior History:</u> The deceased, who had muscular dystrophy, was an only child. She was in the sole care of her 29-year-old mother. Her 35-year-old father was incarcerated. For eight months in 2005 the mother had an open preventive services case because of the child's medical issues. Approximately 10 days prior to the child's death, the child's nursing care agency called the hotline to report that the mother left the child in the care of the child's in-home nurse to check herself into the psychiatric unit of a hospital. A report was taken for inadequate supervision of the child because the nursing care agency was left in the position of hospitalizing the child until another care plan could be made. The child died while in the hospital. The report against the mother was subsequently unfounded because the mother left her child in the care of a nurse, the nurse agreed to ride with the child to the hospital, and the mother recognized her own limitations and the need to seek mental health services. An intact family case, which was opened 3 days following the call to the hotline, remained open for several weeks to help the mother cope with her grief.			

Child No. 79	DOB June 1986	DOD August 2006	Natural
Age at death:	20 years old		
Substance exposed:	No		
Cause of death:	Multiple medical problems		
Reason For Review:	Deceased was a ward		
Action Taken:	Full investigation pending for inclusion in a cluster report		

Narrative: Twenty-year-old medically complex ward became unresponsive while at her school for medically complex children. She was taken by ambulance to the hospital where she was pronounced dead. The ward had been to see her doctor earlier that day for follow-up for a pressure sore on her knee. No other concerns were noted.

Prior History: The ward, who had diagnoses of spastic quadriplegia, scoliosis, cerebral palsy, profound mental retardation, seizure disorder, microcephaly, asthma, and acute bronchospasms, and who was fed by a gastrostomy tube, entered foster care at the age of 2 years after her 21-year-old mother left her home alone. She spent 10 years in one foster home before moving at the age of 12 to the foster home where she remained until her death. The ward's foster mother, who is a registered nurse, provided very good care to the girl. She planned on becoming her adult guardian when the girl turned 21.

Child No. 80	DOB January 1993	DOD September 2006	Natural
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Age at death:	13 years old
Substance exposed:	No
Cause of death:	Seizure disorder due to cerebral palsy
Reason For Review:	Indicated DCP investigation within a year of child's death
Action Taken:	Investigators review of records

Narrative: Thirteen-year-old child with cerebral palsy had a seizure at home. The child had a history of seizures, but reportedly had not had one in three years. After the seizure was over, his family took him to the emergency room. He died in the emergency room an hour-and-a-half later.

Prior History: There was one prior DCP investigation involving the deceased's 6- and 9-year-old brothers. The 6-year-old was observed at school to have 3 welts on his back. He reported that he and his brother were throwing pennies at each other the night before and were hit by their 30-year-old mother with a belt. The 9-year-old had a mark on his arm. The mother admitted that she hit the children with a belt, but said it was the first time she had done that. The children independently confirmed that their mother had never hit them with a belt before, but that she and their father usually took away television and games. The mother was frustrated with the children's behavior and had been seeking help from the children's physician, but he said they were fine. The children's grandfather reported that the children were well-cared for by their parents. The mother was indicated for cuts, bruises, welts. The investigator referred the mother to a local hospital for evaluations for her children and counseling services for the family. She informed the school and requested that school personnel follow-up with the family.

Child No. 81	DOB July 1990	DOD September 2006	Natural
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Age at death:	16 years old
Substance exposed:	No
Cause of death:	Cardiac arrhythmia
Reason For Review:	Teenager was a ward within a year of her death
Action Taken:	Investigatory review of records

Narrative: Sixteen-year-old girl was visiting her boyfriend in another town and was staying with him at his grandmother's home. The boyfriend reported that she was lying in bed in the morning when she began shaking as if she were having seizures. He ran downstairs and called 911, and when he returned she was on the floor unresponsive.

Prior History: The deceased was one of six siblings. In 2002 she and two minor siblings were removed from their 42-year-old mother's care because of sexual abuse to two of the girls by their step-father. This was the second time the children had been removed; they had previously been in foster care from 1991 to 1997. The deceased was returned by the court to her mother's care in April 2006 after the mother completed services. One sibling was returned earlier that year and the other remains in foster care.

Child No. 82	DOB August 2003	DOD September 2006	Natural
Age at death:	3 years old		
Substance exposed:	No		
Cause of death:	Bronchopneumonia		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u>	Three-year-old girl with Down Syndrome was having trouble breathing. Her 36-year-old mother called an ambulance which took the child to the hospital where she was pronounced dead.		
<u>Prior History:</u>	In July 2006 the hotline received a report of medical neglect to the deceased's older brother by the 36-year-old mother. A hospital social worker called the hotline stating that the 4-year-old boy had been hospitalized for a week for a sickle cell crisis and since being discharged, had missed 3 follow-up appointments. The mother admitted to missing 2 follow-up appointments. She explained that in addition to caring for the 4-year-old, she had a 2-year-old with Down Syndrome who required a lot of her time and she had no transportation. The mother said she had asked the hospital for help, but none was provided. The children's primary care physician did not believe the mother was neglectful, but that she needed support, primarily transportation. The social worker arranged transportation for the mother, the child was taken to his appointment, and the report was unfounded.		

Child No. 83	DOB February 2006	DOD September 2006	Natural
Age at death:	7 months old		
Substance exposed:	No		
Cause of death:	Brain injury due to myocardial infarction due to univentricular heart disease		
Reason For Review:	Infant was a ward		
Action Taken:	Investigatory review of records		
<u>Narrative:</u>	Seven-month-old baby, who was born with a rare heart disease, died in the hospital where she had resided since her birth. She had numerous medical problems as a result of her condition.		
<u>Prior History:</u>	The baby, and her 2-year-old sister, had entered DCFS custody two weeks prior to the baby's death. In July, the hotline received a report of substantial risk of physical injury to the 2-year-old when the 21-year-old mother was arrested using the toddler to shoplift. A month later, the hotline was called with a report of substantial risk of sexual injury to the toddler because the mother was knowingly living with a sex offender with the child. While the investigations were pending, the hospital reported that staff had been unable to locate the mother on multiple occasions for consent for medical treatment for the infant, and an allegation of medical neglect was added. Both allegations were indicated, and the girls entered DCFS custody. The 2-year-old child remains in foster care. The mother has not participated in treatment, and the child has a goal of substitute care pending court determination on termination of parental rights.		

Child No. 84	DOB August 2006	DOD October 2006	Natural
Age at death:	Almost 2 months old		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome (SIDS)		
Reason For Review:	Pending DCP investigation at time of infant's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u>	Almost two-month-old baby, who was born a month prematurely, was found unresponsive, face down in his bassinet by his 23-year-old mother. The mother had laid the baby on his side and then took her older child to school. The mother returned 3-1/2 hours later and found the baby not breathing. The 22-year-old father was sleeping in a bed next to the bassinet. An investigation for death by neglect was unfounded.		

Prior History: About a week prior to the infant's death, an investigation was initiated against the mother for an allegation of substantial risk of physical injury to her 5-year-old daughter. School personnel reported that the mother had come to school to pick up her daughter, but the girl had wandered away from the school group. The reporter said that when the girl came back, the mother smacked her in the face and pushed her into the car, all while holding an infant. The mother told the investigator that she was frantic because the school allowed her daughter to leave with someone else. She said that when her daughter came back she took her and put her in the car, but denied hitting her or shoving her as she was holding her newborn. No marks were observed on the child by the investigator or school staff and other interviewees were supportive of the mother. The report was ultimately unfounded.

Child No. 85	DOB August 2006	DOD October 2006	Natural
Age at death: 6 years old			
Substance exposed: No			
Cause of death: Seizure disorder due to cerebral palsy			
Reason For Review: Unfounded DCP investigation within a year of child's death			
Action Taken: Investigatory review of records			
Narrative: Six-year-old child with cerebral palsy, seizure disorder, and autism was found unresponsive at home in the morning by her 46-year-old paternal grandmother, who was her legal guardian. The grandmother reported seeing the child alive an hour earlier.			
Prior History: The deceased came to the Department's attention in March 2005 when her 22-year-old mentally ill mother was admitted to the hospital for psychiatric treatment. The mother was incapable of caring for her three children. The children's 25-year-old father went to court and obtained custody of the deceased's two younger brothers, but wanted his mother to be the legal guardian for his daughter as she had cared for the girl on and off since her birth. The Department assisted the grandmother in obtaining private guardianship of the deceased. In January 2006, the hotline received a report of inadequate supervision to the child by her grandmother. The two were staying at a shelter and the grandmother left late at night to fill a prescription, but did not return right away. The grandmother and child left the shelter the following morning within hours of the hotline report being made. The investigator found them two months later through the maternal grandmother, who reported that the paternal grandmother took good care of the child. The investigator observed the paternal grandmother and child at their apartment, the apartment was appropriate, and the child appeared well-cared for. The grandmother reported that she had had problems with the staff at the shelter, and the investigation was unfounded.			

Child No. 86	DOB September 2006	DOD October 2006	Natural
Age at death: 1 month old			
Substance exposed: Yes, opiates			
Cause of death: Bronchopneumonia			
Reason For Review: Open intact family case at time of infant's death			
Action Taken: Investigatory review of records			
Narrative: One-month-old infant was found unresponsive face up in her crib by her 25-year-old mother. She was taken by ambulance to the hospital where she was pronounced dead. The emergency room contacted the hotline, reporting the infant had a puncture wound on one buttock and a bleeding lesion on the other. An autopsy and investigation by DCP revealed diaper rash for which medication had been prescribed, and the report was unfounded. This was the second of the mother's three children to die. Her first child died two years earlier in a fire when she was 3-1/2 years old. The child's grandmother also died in the fire.			

Prior History: The infant was born substance-exposed to morphine. The 25-year-old mother reported that she took one of her father's morphine pills because of tooth pain. Her father, with whom she and her one-year-old child lived, confirmed this report. The mother was indicated for substance misuse. She and the 31-year-old father agreed to accept DCFS services. The intact family caseworker had seen the family three times prior to the infant's death, and he had given the mother two referrals for substance abuse assessments. The case was closed shortly after the infant's death. The surviving child appeared well-cared for, the mother was working, she completed a drug and alcohol assessment which found that she did not need treatment, and she had the support of her father and boyfriend.

Child No. 87	DOB May 2004	DOD October 2006	Natural
Age at death: 2 years old			
Substance exposed: No			
Cause of death: Tracheal Stenosis			
Reason For Review: Unfounded DCP investigation within a year of child's death			
Action Taken: Investigatory review of records			

Narrative: Two-year-old medically complex child died in the emergency room. The child had CHARGE Syndrome, a pattern of genetic birth defects usually involving the eyes, heart, urinary tract, and ears. There is usually growth retardation and developmental delays. The child required a gastric feeding tube and a breathing tube.

Prior History: The family's only DCFS involvement was a report that was made to the hotline a few weeks prior to the child's death for substantial risk of physical injury to the deceased and her twin and 6-year-old brothers. A representative of DSCC (the Division of Specialized Care for Children) called the hotline to report that she had been at the home to assist the 34-year-old mother with insurance matters related to the child. The mother appeared overwhelmed, asked the reporter to leave, and threatened to beat her boys, who were fighting. The DCP investigation was unfounded just prior to the child's death. The mother reported that on the day the DSCC worker was there, "everything happened at once." Her child's nursing care had been cut in half, she was on the phone with her husband (who was trying to get the insurance company to reinstate the child's nursing services), and her oldest son was acting up. Interviews were conducted with the father, the 6-year-old, a home health care nurse who had been in the home for 3 months, and the mother's doctor. All agreed that the mother would never hurt her children.

Child No. 88	DOB June 2006	DOD October 2006	Natural
Age at death: 4-1/2 months old			
Substance exposed: No			
Cause of death: Peritoneal and retroperitoneal bleed			
Reason For Review: Open intact family case and pending DCP investigation at time of infant's death			
Action Taken: Investigatory review of records			

Narrative: Four-and-a-half-month-old infant was pronounced dead in the emergency room after being brought there by his maternal grandmother who was also his foster parent. He had been released to her custody from the hospital less than 24 hours earlier.

Prior History: In June 2006, 18-year-old mother gave birth to her second child prematurely at 29 weeks gestation. He was born with congenital heart problems. Two months after his birth, the child had to be admitted to the hospital because the mother had not been giving him his medication. The mother was indicated for medical neglect, an intact family case was opened under a court supervision order, and a visiting nurse was put in place. In September 2006 the infant was hospitalized and had heart surgery. A month later, the visiting nurse called the hotline to report that the mother had not given the infant his medication in at least 3 days, the child was having trouble breathing, and the mother was refusing to take the infant to the emergency room, insisting that he was fine. A DCP investigator responded within 30 minutes, found the infant in distress, and called an ambulance for the child. The 3-year-old sibling was placed with the maternal grandmother pursuant to a safety plan, and two days later the Department was granted temporary custody of the children. The infant was discharged to his grandmother's care the day before his death.

Child No. 89	DOB September 2006	DOD November 2006	Natural
Age at death: 2 months old Substance exposed: No Cause of death: Complications from prematurity Reason For Review: Child was a ward Action Taken: Investigatory review of records			
Narrative: Two-month-old ward died while in the hospital. The infant was born prematurely at 27 weeks gestation with numerous complications, including bowel, brain, heart, and lung problems. He never left the hospital following his birth.			
Prior History: Thirty-three-year-old mother has given birth to nine children, four of whom were born substance-exposed. The mother has a history with DCFS dating to 1993. She has lost custody of all of her children, as have the fathers. The mother was enrolled in a drug treatment program at the time of the infant's birth, and the baby was born without drugs in his system. The mother was indicated for substantial risk of physical injury to the newborn based on her history and because she dropped out of treatment after the birth of the baby and was not prepared to care for him.			

Child No. 90	DOB February 1991	DOD November 2006	Natural
Age at death: 15 years old Substance exposed: No Cause of death: Septic shock Reason For Review: Child was a ward Action Taken: Investigatory review of records			
Narrative: Fifteen-year-old medically complex ward was brought to the hospital by ambulance in respiratory distress and with a low heart rate. She died in the hospital the following day. Her foster parents of fourteen years were with her when she died.			
Prior History: The deceased was born prematurely. She was diagnosed with cerebral palsy, cortical blindness, severe mental retardation, and seizure disorder. She had undergone numerous surgeries. The girl, who functioned at the level of a one-year-old when she died, entered foster care at 5 months of age. Her parents surrendered their parental rights within a few months. The ward was given excellent care by her foster parents, and she lived beyond her initial life expectancy.			

Child No. 91	DOB September 1986	DOD December 2006	Natural
Age at death: 20 years old Substance exposed: No Cause of death: Cerebral palsy Reason For Review: Deceased was a ward Action Taken: Full investigation pending for inclusion in a cluster report			

Narrative: Twenty-year-old medically complex ward was noticed by his nursing home staff to be having difficulty breathing. Staff performed CPR and called 911. The ward was transported to the hospital where he was pronounced dead.

Prior History: The ward had been born by emergency C-section with the use of forceps. During labor, he suffered oxygen loss and subsequent brain damage. He began having seizures within 9 hours after his birth. He was subsequently diagnosed with cerebral palsy, seizure disorder, scoliosis, visual impairment, and profound mental retardation. The child entered foster care in 1988 after his mother was indicated for medical neglect, malnutrition, and failure to thrive. In 1989 the ward was placed in the nursing care facility where he remained until his death. His mother last visited him in 1998. She made sporadic phone contact with staff and sent an occasional Christmas card.

Child No. 92	DOB September 2006	DOD December 2006	Natural
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Age at death:	3 months old
Substance exposed:	No
Cause of death:	Sudden Infant Death Syndrome (SIDS)
Reason For Review:	Pending DCP investigation at time of child's death
Action Taken:	Investigatory review of records

Narrative: Three-month-old baby died while sleeping at the babysitter's house. The 16-year-old mother went to the house to pick up her baby and found him unresponsive. The babysitter had an application pending for a day care home license. She withdrew the application following the baby's death.

Prior History: At the time of the baby's death, there was a pending DCP investigation against the mother for inadequate supervision. The mother had left the baby with a friend while she went out of town to look for the baby's father. The maternal grandmother contacted police to conduct a well-baby check after the mother and baby failed to return home. Police took protective custody of the baby and called DCFS because of drug trafficking in the neighborhood where the baby was staying. The Department released the baby to the maternal grandparents pursuant to a safety plan until the mother returned. At the time the baby died, the mother was trying to set up appropriate child care for the baby while she went to school. The mother was subsequently indicated on the pending report of inadequate supervision because she left the baby with a friend for six days without leaving contact information, and the friend was not a suitable child care plan because she was known to police as being involved in drug activity.

Child No. 93	DOB September 2007	DOD December 2006	Natural
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Age at death:	3 months old
Substance exposed:	No
Cause of death:	Sudden Infant Death Syndrome (SIDS)
Reason For Review:	Unfounded DCP investigation within a year of infant's death
Action Taken:	Investigatory review of records

Narrative: Three-month-old baby was found face down in his crib by his 21-year-old mother. The baby had been taken to the doctor two days earlier because of acid reflux and was prescribed Zantac.

Prior History: Eleven months prior to the infant's death, the mother was investigated for cuts, welts and bruises to her 5-year-old daughter. The girl had come to school with a bruise on her face and told staff her mother hit her. An investigator interviewed the girl who said her mother hit her, but that she had never done that before. The mother denied hitting the girl. The investigator developed a safety plan where the child would stay with a maternal aunt. The police also conducted an investigation. The girl told police that her mother's boyfriend had hit her. An investigator interviewed the mother and boyfriend who both gave the same story, that they had noticed the mark a few days earlier, asked the child about it, and she said she did not know how she got it. The mother and boyfriend continued to deny causing any injury to the child; investigators interviewed school personnel who stated the child never had marks before and had not come to school with any more marks since. Both the police and the Department unfounded the allegation with the rationale that the perpetrator denied the allegations, the child was not consistent, and the child's doctor told police that the bruise was not necessarily from abuse.

Child No. 94	DOB August 1986	DOD January 2007	Natural
Age at death:	20 years old		
Substance exposed:	No		
Cause of death:	Acute Bronchial Pneumonia		
Reason For Review:	Deceased was a ward		
Action Taken:	Preliminary investigation		
Narrative: Twenty-year-old ward was taken to the hospital by her boyfriend after she fell down an escalator while they were fighting (she may have fainted). The ward was admitted to the hospital where she died 2 days later from pneumonia. The ward had not been feeling well lately, and her worker had been encouraging her to see a doctor.			
Prior History: The ward was a parent to a 4-year-old boy with her boyfriend. The ward had been in an independent living program for several years and had been doing well. She was also receiving teen parent services. The girl had been a ward since 1999. Her nine younger siblings are in foster care or have been adopted. The Department is helping the ward's 59-year-old grandmother obtain legal guardianship of her great-grandson; the process is almost complete.			

Child No. 95	DOB October 2007	DOD January 2007	Natural
Age at death:	3 months old		
Substance exposed:	Yes, opiates		
Cause of death:	Sudden Infant Death Syndrome (SIDS)		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		
Narrative: Three-month-old twin boys were put to bed at approximately 11:00 pm by their 56-year-old grandmother, who was also their foster parent. When she went to check on them the next morning around 9:00 am, one of the twins was unresponsive. The grandmother, who is a nurse, performed CPR on the infant and called an ambulance. He was taken to the hospital where he was pronounced dead.			
Prior History: The hotline was called in October 2006 when the twins were born substance-exposed to opiates. DCP investigated allegations of substance misuse by neglect to the twins and substantial risk of physical injury to the twins and their 1- and 6-year-old siblings. The mother was unemployed and homeless and rarely visited the twins while they were hospitalized following their births. She admitted to a prescription drug problem and felt she needed inpatient substance abuse treatment. The mother was indicated for both allegations, and the children entered foster care. The twins and their 1-year-old sibling were placed with the maternal grandmother, and the 6-year-old was placed with the maternal grandfather who had cared for her most of her life. The children remain in their placements.			

Child No. 96	DOB August 2005	DOD February 2007	Natural
Age at death:	2 years old		
Substance exposed:	No, but the mother had a history of methamphetamine use		
Cause of death:	Viral encephalitis probably from herpes simplex infection		
Reason For Review:	Child was a ward		
Action Taken:	Full investigation pending		
<u>Narrative:</u>	Two-year-old medically complex child was brought to the hospital where she was pronounced dead. Her relative foster parents had been in the process of adopting her, and an interim order of adoption had been entered a month prior to her death. The adoption was finalized two days after the child's death so her death certificate could reflect the adoptive parents' name.		
<u>Prior History:</u>	The hotline was called in early September 2004 by a hospital social worker requesting a child welfare services referral after the child was born at 34 weeks gestation with multiple medical complications. Her developmentally delayed 20-year-old mother tested positive for methamphetamines during her pregnancy, but not at the child's birth. The deceased was the mother's second child. The mother resided with her 4-year-old child, her parents, and her 15-year-old sibling. A child welfare services case was opened to assist the mother with transportation to and from the hospital to learn to care for the child. In late September, the worker called the hotline with an allegation of substantial risk of physical injury to the mother's two children and her 15-year-old sibling after the worker learned of possible methamphetamine use in the home. The mother also failed to regularly visit the infant in the hospital. DCFS sought custody of the children, but was granted custody of the deceased only. She was placed in the home of a maternal aunt. The other two children were allowed to remain in their home.		

Child No. 97	DOB June 2004	DOD March 2007	Natural
Age at death:	2-1/2 years old		
Substance exposed:	No		
Cause of death:	Muscular Dystrophy		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u>	Two-and-a-half-year-old medically complex child was discovered not breathing by his parents who started CPR and called 911. The child was taken to the hospital where he was pronounced dead. The mother saw the child breathing less than an hour earlier while he was lying on the floor in front of the TV. While the autopsy stated that the underlying cause of the child's death was muscular dystrophy, it also noted that it could not be ascertained whether the proximal cause of death was asphyxia because of an obstruction of the child's ventilator tubing.		
<u>Prior History:</u>	Five months prior to the child's death, a home health care nurse called the hotline to report that the child's parents smoked while in the same room as the child, who was on a ventilator, and that the father watched pornography in the presence of his three other children. The report was unfounded. The nurse left the home health care agency and could not be interviewed. Two other nurses, who provided 24-hour care for the child, denied the allegations and reported that the parents took good care of the child. The child's doctor reported that there was no order that the parents could not smoke around the child. The parents and their 9-, 6-, and 3-year-old children denied the allegations, and the parents showed the investigator a back porch where they smoked.		

Child No. 98	DOB August 2006	DOD March 2007	Natural
Age at death:	7 months old		
Substance exposed:	No		
Cause of death:	Myocarditis		
Reason For Review:	Infant was the child of a ward		
Action Taken:	Investigatory review of records		

Narrative: Seven-month-old infant had been ill for several days with vomiting, fever, and sweating. The 16-year-old mother and the infant's father took the infant to the emergency room the evening before his death for uncontrollable vomiting. The infant was admitted to the hospital where he died the following morning.

Prior History: The teen mother is one of five siblings who have been in DCFS care since June 2005. The children are placed with a maternal aunt, with whom the teen was living when her child died. The mother was receiving services appropriate for a teenaged mother including parenting classes, and she was also attending an alternative high school program. The infant's father and extended family were also actively involved in the care of the infant.

Child No. 99	DOB February 1994	DOD April 2007	Natural
Age at death: 11 years old			
Substance exposed: No, however, 2 siblings were born substance-exposed			
Cause of death: Myocarditis			
Reason For Review: Child was a ward			
Action Taken: Investigatory review of records			
Narrative: Thirteen-year-old ward, who had been psychiatrically hospitalized since January, went into cardiac arrest and died. The hospital had performed a cardiac work-up on the child earlier in the day that did not reveal any acute cardiac issues.			
Prior History: The ward's 42-year-old mentally ill mother has a history with DCFS dating to 1991 when she gave birth to her first substance-exposed infant. That child entered foster care a couple of months later. The mother subsequently gave birth to three children, all of whom entered foster care upon their births. The children's fathers are non-involved. The mother resides in a nursing home for the mentally ill. The two oldest children are in the subsidized guardianship of an aunt, and the youngest remains in foster care.			

Child No. 100	DOB January 2001	DOD April 2007	Natural
Age at death: 6 years old			
Substance exposed: No			
Cause of death: Cerebral palsy			
Reason For Review: Unfounded DCP investigation within a year of child's death			
Action Taken: Investigatory review of records			
Narrative: Six-year-old medically complex child was fed by his 29-year-old caretaker, the father of his younger sister, and placed in front of the TV in his wheelchair. When the man checked on him a few minutes later, the child was unresponsive. The child was taken by ambulance to the hospital where he was pronounced dead.			
Prior History: The 24-year-old mother of three was indicated for inadequate supervision of her 7-year-old daughter in 2005, and she was court-ordered to take parenting classes. A year later, the deceased's school called the hotline with concerns about bruises, a possible bed sore, and cleanliness. A report for medical neglect and cuts, welts, bruises was unfounded. The child's pediatrician vouched for the mother's good care of the child. The child was at a new school and personnel were being cautious. The investigator arranged for the mother and school to communicate better about the child.			

Child No. 101	DOB February 2007	DOD April 2007	Natural
Age at death: 3 months old			
Substance exposed: No			
Cause of death: Chondrodysplasia Punctata			
Reason For Review: Unfounded DCP investigation within a year of child's death			
Action Taken: Investigatory review of records			

Narrative: Three-month-old infant with Chondrodysplasia Punctata, a severe form of dwarfism, died in the hospital. He was ventilator dependent after birth and never left the hospital.

Prior History: In February 2007, the Department investigated a report of substantial risk of physical injury to the infant by his 27-year-old mother, who was reported to have two children who were not in her custody. The hospital social worker denied calling the hotline to make a report, stating she was only trying to find out if the Department had removed the mother's two children from her custody. The mother had two prior indicated reports, one in 2002 and one in 2003, but her children were not removed from her care. The mother informed the investigator that she had gastric bypass surgery prior to becoming pregnant with the infant, and she had complications causing her to be ill, so she sent her older child to stay with her sister, and the younger child was with her father. The investigation was unfounded because there was no evidence that the hospitalized infant was at any risk.

Child No. 102	DOB April 2007	DOD May 2007	Natural
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Age at death:	1 week old
Substance exposed:	No
Cause of death:	Congenital heart disease
Reason For Review:	Open intact family case at time of infant's death
Action Taken:	Investigatory review of records

Narrative: One-week-old infant born with multiple medical problems died in the hospital after his parents decided to remove him from a ventilator.

Prior History: The 35-year-old mother and 41-year-old father have a history of domestic violence. In August 2005, the father was indicated for physical abuse of his 3-year-old step-son, after the mother reported him to the hotline. Services were offered, but the family refused. In November 2006 a report of substantial risk of physical injury to the three children by the parents was unfounded, but an intact family case was opened. The worker set up domestic violence services for the mother, assisted her in obtaining an order of protection against the father, and arranged for developmental services for the children. After seven months (and subsequent to the baby's death), the mother moved to a new town, and she declined further DCFS services.

Child No. 103	DOB January 2004	DOD May 2007	Natural
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Age at death:	3 years old
Substance exposed:	No
Cause of death:	Bronchopneumonia
Reason For Review:	Pending DCP investigation at time of child's death
Action Taken:	Investigatory review of records

Narrative: Three-year-old medically complex child was found unresponsive by his 26-year-old father. The child had been born 3 months prematurely and had severe medical problems as a result. He outlived his doctors' expectations.

Prior History: The family has a history with DCFS dating to 2000 when the 23-year-old mother was indicated for medical neglect of another of her four children. An intact family case was open until 2002. In August 2005, the intact family case was reopened for neglect; it was closed in February 2006. At the time of the child's death, there was a pending DCP investigation. An anonymous reporter called the hotline alleging that the 7- and 10-year-old boys ran the streets without supervision and that the mother smoked around the deceased. Those allegations were ultimately unfounded, but an allegation of environmental neglect was added and indicated. A decision to reopen the intact family case was made three days prior to the child's death and a meeting was to have occurred at the family's home on the day the child died. Petitions were filed by the State's Attorney's office and the family is receiving intact family services under a court order for continuance under supervision rules.

Child No. 104	DOB February 1993	DOD May 2007	Natural
Age at death:	14 years old		
Substance exposed:	No		
Cause of death:	Respiratory failure due to aspiration pneumonia		
Reason For Review:	Teenager was a ward		
Action Taken:	Preliminary investigation		
<u>Narrative:</u>	Medically complex 14-year-old ward was admitted to the hospital from his skilled nursing facility because he was experiencing respiratory distress. The ward was diagnosed with pneumonia and remained in the hospital until his death three days later.		
<u>Prior History:</u>	The deceased was medically complex with diagnoses of Schizencephaly (a rare developmental birth defect causing brain abnormalities), severe cerebral palsy, seizure disorder, profound mental retardation, and scoliosis. He entered foster care in May 1995 because of medical neglect. The 16-year-old mother had left the child with his maternal grandmother who was found unable to care for the child given his special needs. The mother was in frequent contact with the skilled nursing facility and was at her son's bedside at his death. She and her husband have five children. The Department has not been involved with those children.		

Child No. 105	DOB March 2007	DOD May 2007	Natural
Age at death:	2 months old		
Substance exposed:	No, but the mother has a history alcohol abuse		
Cause of death:	Sepsis, with viral pneumonia a significant contributing condition		
Reason For Review:	Infant was a ward		
Action Taken:	Full investigation pending		
<u>Narrative:</u>	Two-month-old ward was found appearing blue by her maternal aunt at about 10:30 in the morning. The maternal grandmother began CPR and called 911. The infant was taken to the hospital where she was later pronounced dead. The infant had woken up during the night and once in the morning, and she was irritable and constipated.		
<u>Prior History:</u>	The 28-year-old mother has a history with DCFS dating to 1999. An intact family case was opened in November 2002 and closed in October 2003 after the mother agreed to allow her two children, born in 1993 and 1999, to live with their maternal grandmother. When the deceased was 6 days old, police stopped the mother for driving under the influence of alcohol. The deceased and her 2-year-old brother were not restrained properly, and the mother's blood-alcohol level was 0.165. At the time of the incident, the children's 35-year-old father was in jail for possession of a dangerous substance. The police released the children to their maternal grandmother, who returned the children to their mother when she was released from jail a couple of days later because she was not told by anyone that she should not. DCFS took protective custody of the children nine days after the drunk driving incident. The 2-year-old child is currently in foster care and is placed with the maternal grandmother.		

Child No. 106	DOB June 2007	DOD June 2007	Natural
Age at death:	0		
Substance exposed:	No		
Cause of death:	Extreme prematurity		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation pending		

Narrative: Infant born at 20.5 weeks gestation died one hour after birth. Three days after the infant's birth, the hotline was called with a report of substantial risk of physical injury to the infant's 17-year-old mother by her 42-year-old father. Ten days prior to the hotline report, the pregnant 17-year-old and her father got into an argument over car keys, and the father twisted the girl's arm, broke several of her fingernails, pushed her to the floor, and repeatedly hit her arm. The father was arrested on domestic battery charges, but they were dropped when the girl and her two sisters refused to testify against the father. The investigation was unfounded because the girl refused to speak to the investigator about the incident and would not pursue charges against her father. The altercation between the girl and her father was not thought to have caused the infant's premature birth.

Prior History: In April 2007, the hotline was called with a report of substantial risk of physical injury to the deceased and her two sisters, ages 14 and 15. The girls' father was arrested and charged with attempted murder for beating his wife in the head with a barbell. A school social worker reported that the mother told her that the girls were afraid that their father was going to come back and kill them all. The investigation was unfounded. The mother admitted to the DCP worker that there had been domestic violence in her marriage on and off for eighteen years, and she said she was now going to leave the father. The girls were interviewed, but they denied ever seeing any physical altercations between their parents or telling anyone they were afraid their father would kill them. They were not home when their mother was beaten.

Child No. 107	DOB August 2005	DOD June 2007	Natural
Age at death:	1-1/2 years old		
Substance exposed:	No		
Cause of death:	Chronic respiratory insufficiency due to costo-cerebro-mandibular syndrome		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
Narrative: One-and-a-half-year-old medically complex child died in the hospital. He had lived in a long-term care facility his entire life.			
Prior History: The child's 27-year-old mother has DCFS involvement dating to 2002 when she was indicated for inadequate supervision and substantial risk of physical injury to her 1-year-old son. An intact family case was open from August 2002 to February 2004. In January 2007, the 5-1/2-year-old child's school called the hotline stating the child had abrasions on his elbows that looked like rug burns, and the child said his mother dragged him across the floor. The mother told the investigator that the child had ADHD and refused to take his medication and get ready for school, and he crawled around the floor on his elbows having a fit. The child's aunt, who lived in the home, said she was present at the time and witnessed the child crawling on his elbows while having a tantrum. The maternal grandmother vouched for her daughter's good care of the child, and the investigation was unfounded.			

Child No. 108	DOB May 2006	DOD June 2007	Natural
Age at death:	13 months old		
Substance exposed:	No		
Cause of death:	Dilated cardiomyopathy due to bronchopulmonary dysplasia due to prematurity		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Investigatory review of records		
Narrative: Twenty-six-year-old mother was changing her 13-month-old infant's diaper when she noticed the infant's breathing was shallow and her lips were turning blue. The mother called 911 and emergency services personnel took the infant to the hospital where she was pronounced dead.			

Prior History: The deceased was a twin. The twins were born at 23 weeks gestation and were medically complex. The deceased's twin spent four months in the hospital following her birth, and the deceased spent 10 months in the hospital before her release. In November 2006, the hotline was called with a report of medical neglect to the twins by their parents and a concern about domestic violence in the home. The medical neglect allegation was unfounded, but the parents were indicated for substantial risk of physical injury to the twins, and an intact family case was opened. The mother and father split up, the mother got a restraining order against the father, and she completed domestic violence counseling. She cared for the one twin at home with the assistance of her grandmother and home nursing care staff, and she visited the other twin in the hospital every other day until the infant returned home.

Child No. 109	DOB May 2007	DOD June 2007	Natural
Age at death: 5 weeks old Substance exposed: No Cause of death: Bronchopneumonia due to Myocardial fibroelastosis Reason For Review: Open preventive services case at time of child's death Action Taken: Investigatory review of records			
Narrative: Five-week-old infant was found unresponsive in her car seat in the morning by her parents. The infant was born nine weeks prematurely with a congenital heart disorder and spent the first few weeks of her life in a hospital intensive care unit. She had only been home two weeks at the time of her death.			
Prior History: The deceased was the 28-year-old mother's seventh child. The mother has a history with DCFS dating to 2003 when she was indicated for medical neglect to her 7-year-old daughter for continually failing to get treated the child's severely decayed teeth, which resulted in infection. An intact family case was opened, and it remained open for one-and-a-half years. Almost two years later, the mother called DCFS asking for help because her family was homeless, and in October 2006, an intact family case was opened. It remains open. Workers are helping the mother and 22-year-old father with parenting skills, budgeting, and home cleanliness.			

Child No. 110	DOB May 2007	DOD June 2007	Natural
Age at death: 5 weeks old Substance exposed: Yes, cocaine Cause of death: Septic shock, bronchopulmonary dysplasia, and superimposed pneumonia Reason For Review: Infant was a ward Action Taken: Preliminary investigation			
Narrative: Five-week-old ward, who was born prematurely and substance-exposed at 27 weeks gestation, suffered from serious medical problems. He died before ever leaving the hospital after his birth. His mother was indicated for substance misuse, substantial risk of physical injury, and death by neglect.			
Prior History: The 36-year-old mother has a history with DCFS dating to 1993. The deceased was the mother's tenth child, the fifth of whom was born substance-exposed. The mother has lost custody of all of her children. In 2004, following the birth of her fourth substance-exposed infant, the mother engaged briefly in substance abuse treatment, but dropped out. That child was adopted by the maternal grandmother who has the other children.			

Child No. 111	DOB May 2007	DOD June 2007	Natural
Age at death:	1 month old		
Substance exposed:	No, but mother tested positive for cocaine and marijuana one week before birth		
Cause of death:	Necrotizing Enterocolitis due to extreme prematurity		
Reason For Review:	Open placement case and pending DCP investigation at time of infant's death		
Action Taken:	Investigatory review of records		
<u>Narrative:</u>	<p>Infant was born at 24 weeks gestation and weighed less than a pound. He remained in the hospital, where he was expected to stay for several months because of his prematurity. At one month of age, the infant died in the hospital from an intestinal infection common to premature infants. When the infant was born, the hotline was called with a report of substantial risk of physical injury to the infant. While the mother and infant tested negative for drugs at the time of the infant's birth, one week prior to his birth the mother tested positive for cocaine and marijuana. The infant died while the investigation was pending, and it was subsequently unfounded</p>		
<u>Prior History:</u>	<p>The infant's 25-year-old mother was a ward as a child. In March 2004, her first two children entered foster care at ages 1 and 2, following an indicated report of failure to thrive of the younger child. In March 2007, her second two children entered foster care at ages 1-1/2 and 2-1/2 after the mother tested positive for cocaine and marijuana and an incident of domestic violence in which the 27-year-old father stabbed the mother in the hand. All four children are placed with their paternal grandparents. The two oldest have goals of subsidized guardianship and the two youngest have goals of return home.</p>		

TOTAL DEATHS BY CASE STATUS FY 2000 TO FY 2007

Fiscal Year	2000		2001		2002		2003		2004		2005		2006		2007	
Case Status	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Ward*	29	31%	43	41%	23	24%	29	23%	31	22%	37	27%	17	20%	25	22%
Unfounded DCP	7	7%	14	13%	7	7%	20	15%	29	21%	29	20%	25	29%	35	31%
Pending DCP	10	11%	6	6%	8	8%	15	12%	12	8%	15	11%	7	8%	16	14%
Indicated DCP	8	8%	14	14%	9	9%	12	10%	6	4%	1	1%	1	1%	6	5%
Child of Ward	5	5%	4	4%	6	6%	12	10%	2	1%	2	1.5%	1	1%	4	4%
Open Intact	9	9%	12	12%	20	21%	19	15%	15	11%	31	22%	20	23%	13	12%
Closed Intact	5	5%	2	2%	8	9%	7	5%	13	9%	0	0	1	1%	2	2%
Open Placement	3	3%	4	4%	5	5%	2	1.5%	10	7%	3	2%	2	2.5%	1	1%
Closed Placement (Ret Home)	3	3%	1	1%	4	4%	2	1.5%	2	1%	0	0	0	0	4	4%
Split Custody	10	11%	0	0	4	3%	1	1%	7	6%	2	1.5%	2	2.5%	1	1%
Others	7	7%	3	3%	3	4%	8	6%	12	10%	19	14%	10	12%	4	4%
Total	96	100%	103	100%	97	100%	127	100%	140	100%	139	100%	86	%100	111	100%

*FY 07 includes one former ward.

CHILD DEATHS BY DCFS CASE STATUS AND MANNER OF DEATH

FISCAL YEAR	2000	2001	2002	2003	2004	2005	2006	2007
Total Deaths	96	103	97	127	140	139	86	111
Ward	29	43	23	29	31	37	17	24
Natural	13	20	14	18	16	28	10	13
Accident	6	9	3	3	3	1	2	6
Homicide	7	9	3	6	8	5	4	3
Suicide	0	0	3	1	2	3	0	0
Undetermined	3	4	0	0	2	0	1	2
Unfounded DCP Investigation	7	14	7	20	29	29	25	35
Natural	0	5	2	9	16	17	8	9
Accident	2	6	0	6	8	8	8	16
Homicide	4	2	3	5	2	1	7	5
Suicide	0	0	1	0	0	0	0	1
Undetermined	1	1	1	1	3	3	2	4
Pending DCP Investigation	10	6	8	15	12	15	7	16
Natural	0	1	7	6	6	4	3	8
Accident	5	1	1	3	1	5	2	2
Homicide	3	3	0	5	3	3	2	4
Suicide	0	0	0	0	0	0	0	0
Undetermined	2	1	0	1	2	3	0	2
Child of Ward	5	4	6	12	2	2	1	4
Natural	1	1	1	6	1	2	1	2
Accident	1	1	2	3	1	0	0	0
Stillbirth	2	0	0	0	0	0	0	0
Homicide	0	0	2	2	0	0	0	0
Suicide	0	0	0	0	0	0	0	0
Undetermined	1	2	1	1	0	0	0	2
Indicated DCP Investigation	8	14	9	12	6	1	1	6
Natural	1	4	7	7	3	1	0	2
Accident	4	7	0	4	3	0	0	4
Homicide	1	1	1	0	0	0	0	0
Suicide	0	0	0	0	0	0	0	0
Undetermined	2	2	1	1	0	0	1	0
Open Intact	9	12	20	19	15	31	20	13
Natural	6	6	6	4	8	23	12	5
Accident	0	5	7	10	1	5	3	4
Homicide	1	1	5	1	1	2	4	2
Suicide	0	0	0	0	1	0	0	0
Undetermined	2	0	2	4	4	1	1	2
Closed Intact	5	3	8	7	13	0	1	2
Natural	2	2	2	3	3	0	0	1
Accident	2	0	4	1	5	0	1	1

Homicide	1	0	0	3	4	0	0	0
Suicide	0	0	0	0	0	0	0	0
Undetermined	0	1	2	0	1	0	0	0
Open Placement	3	4	5	2	10	3	2	1
Natural	3	2	4	2	9	2	2	1
Accident	0	0	0	0	0	0	0	0
Homicide	0	0	0	0	1	1	0	0
Stillbirth	0	2	0	0	0	0	0	0
Undetermined	0		1	0	0	0	0	0
Closed Placement	3	1	4	2	2	0	0	0
Natural	3	0	3	1	1	0	0	0
Accident	0	1	0	0	0	0	0	0
Homicide	0	0	1	1	1	0	0	0
Suicide	0	0	0	0	0	0	0	0
Undetermined	0	0	0	0	0	0	0	0
Split Custody	10	0	4	1	7	2	2	1
Natural	0	0	2	1	3	1	1	0
Accident	1	0	0	0	2	1	1	0
Homicide	1	0	1	0	2	0	0	0
Stillbirth	3	0	0	0	0	0	0	0
Undetermined	5	0	1	0	0	0	0	1
Adopted	0	2	2	1	1	0	0	0
Former Ward	5	1	0	1	1	0	1	1
Open Return Home	0	0	0	1	0	3	0	4
Closed Return Home	2	0	0	0	0	0	0	0
Homicide by a ward *	1	0	1	2	0	0	0	0
Interstate compact	0	1	0	0	1	0	1	0
Open preventive service	0	0	1	1	3	13	5	2
Closed preventive service	0	0	0	2	1	0	0	0
Subsidized Guardianship	0	0	0	1	0	0	0	0
Child of former ward	0	0	0	0	3	1	0	0
Extended family support	0	0	0	0	2	2	0	1
Child Welfare Referral	0	0	0	0	0	0	3	1

* Three of the four wards who committed homicide killed another ward or a child of a ward and the deaths were listed in that category; therefore, only one of those deaths is included in the final total.

GENERAL INVESTIGATIONS

GENERAL INVESTIGATION 1

ALLEGATION

A drug testing laboratory contracted to perform drug toxicology testing on Department clients received specialized treatment and was delinquent in taxes owed to the State.

INVESTIGATION

The OIG reviewed contracts and billing statements submitted by the drug testing laboratory. The OIG noted that the amount of the agency's contracts had increased over the course of several years, despite the fact that the client base for drug testing had decreased over that time. The OIG analysis of the billings noted irregularities on the face of the billings because the billings showed clients being tested at regular intervals, such as every Monday of the month. For drug test results to be reliable, they should be requested at random intervals. In fact, the contract program plans required that the drug drops be random. In addition, the OIG noted that many clients were tested regularly (4 to 5 times each month) for up to nine months, exceeding generally accepted drug testing standards.

The OIG impounded sign-in sheets documenting when the individuals required to submit to drug tests provided samples. The OIG analysis for the year 2006 found that approximately 70% of the tests for which the Department was billed were not supported by the sign-in sheets. In addition, the OIG reviewed individual case files in depth and reviewed random samples of case files to determine whether there was support for the billing. In one of the cases reviewed, the client was incarcerated during the time the drug testing laboratory had billed the Department for conducting drug testing on the client. In each case, the amount of overbilling was approximately 70%. The contracts with the Department over the previous seven-year period had been for approximately \$700,000 per year.

The OIG impounded all records for the prior three years that supported billings to the Department. The OIG examined the internal structure that had failed to note the problems with the billings. The signatures of the contract liaison and staff from the vouchering unit were necessary to authorize billings before the agency could be paid, requiring both to certify that the "*services or merchandise*" represented in the voucher "*has been received and complies with the request,*" for services from the Department. Despite this, neither staff noticed that approximately 70% of the billings had not, in fact been delivered.

The OIG learned that the Department's contract liaison assigned to monitor the agency had not visited the agency in several years. His review of billings, necessary for approval to pay the agency, consisted of ensuring that the names provided on the billing summaries were clients of the Department and checking for math errors. He did not note that the billings did not appear to reflect "random" drug drops or that all clients always showed up for their drug drops without fail four to five times each month. Nor did he conduct any random review of documents to determine whether there was support for the billings. Although the Department had an approval process whereby caseworkers had to receive centralized approval before they could refer clients for drug drops, there was no connection between the centralized approval process and the approval of the billing summaries submitted. The OIG also learned that contrary to Department policy, the contract liaison had received Christmas gifts from the agency and failed to report them to his supervisor. The liaison claimed that he had given the gifts away but provided no documentation of having done so.

Regarding the allegation of tax delinquencies, the OIG found that although the agency had no current tax delinquencies, in prior contract years it had significant federal and state tax delinquencies and had violated the

contract by warranting, each contract year, that it did not owe any funds to the State or the federal governments.

The OIG immediately notified the Department to stop contracting with the agency and placed a hold on all pending payouts to the agency. The OIG presented its findings to the Cook County State's Attorney, which is currently pursuing prosecution of the owner of the agency.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should cease contracting with the agency or its principal, and should put an immediate hold on any pending payouts to the agency.

The Department has ceased contracting with the agency.

2. The OIG will refer this case to the State's Attorney for possible criminal prosecution. The Department should audit the drug testing laboratory and seek civil recovery of unsubstantiated billing.

The Inspector General's Office referred the agency for criminal prosecution. Invoices were submitted to auditors hired by the Governor's Office.

OIG Update: The State's Attorney has committed to seek restitution along with criminal prosecution.

3. The new Contract Monitoring Protocol should include toxicology contracts. Toxicology contract monitoring should include a specific provision requiring review of Approval Forms and incorporation of guidelines developed by Service Interventions.

The Department agrees.

4. The Department should develop an electronic system for tracking and linking resource approvals, caseworker sign-offs on service delivery and billing reviews.

The Department has developed an electronic tracking process for drops and their results. The contract administration unit has not been introduced to this process yet.

5. The Department should have a written policy, developed by the Service Intervention Division, dictating the requirements for drug and alcohol drops. The policy and subsequent training should specify red flags that the Contract Liaison should look for in reviewing the Billing Summaries.

The Department has a work group to update the program plan and protocol for all toxicology providers. An inter-division work group, including Office of the Inspector General staff has been convened to address drug testing issues. The work group is developing standards for client drug testing, frequency and duration of testing, drugs to be included in test panels, program plan requirements for drug testing contractors, review criteria for contract monitors, use of breathalyzers to test for alcohol, and use of confirmation tests on positive urine screens. The group is planning to complete its recommendation in the fourth quarter of FY2008.

6. Drug and alcohol toxicology contracts should be competitively bid.

The Department agrees. This will be implemented with FY09 contracts.

7. The contract liaison should be disciplined for receiving gifts from the principal of a contract he

monitored without notifying his supervisor and without documenting donation of the gifts to charity and for failing to note that the billings did not comport with the contractual requirement for random drops.

The employee was temporarily suspended.

8. The findings of the outside auditors with respect to the drug testing laboratory billings for years 2004 and 2005 should be shared with the State's Attorneys Office for the purpose of securing restitution for the Department in conjunction with the criminal prosecution.

The audit is being managed by the Governor's Office. The Director will convey his belief that this should be done to the appropriate parties. A request will also be made that any funds recovered are directed to transitional living instead of to the general revenue fund.

9. The Department should expand the audit of the drug testing laboratory to include years prior to 2004, to the extent that such records are available.

The audit is being managed by the Governor's Office. The Director will convey his belief that this should be done to the appropriate parties.

GENERAL INVESTIGATION 2

ALLEGATION

A mother abandoned her six year-old son at an outdoor public festival. At the time, the family had an open case for intact services with the Department and was receiving counseling from a private agency.

INVESTIGATION

The mother, a former ward, and her son had come to the attention of the Department three years earlier after she called the hotline and reported she had locked herself in the bathroom to prevent herself from hurting the boy. During the subsequent child protection investigation, the mother stated she took this measure every day and had become overwhelmed by the responsibility of caring for a child alone. The mother was indicated for risk of physical injury and the boy was taken into foster care where he remained for 16 months. While the boy was in care, the mother participated in a psychiatric evaluation which identified a need for counseling to address her issues of depression and isolation. One year after being reunited with her son, the mother left the then five year-old home alone while she went to work. She was indicated for inadequate supervision and a case was opened for intact family services and referred to a private agency.

The intact referral packet provided to the private agency contained information regarding the family's history, including the mother's lack of support, the boy's behavioral problems in school and the chaotic state of their household. The private agency therapist assigned to the case conducted a family assessment, however her analysis focused entirely on the mother with the only mention of the son being the mother's report he was functioning well. The therapist did not request a psychological evaluation of the mother and contradicted herself during an interview with the OIG as to whether she was aware one had previously been performed. The therapist said she generally requested such evaluations but did not in this instance because she possessed no information the mother suffered from depression.

The therapist also did not seek to verify the mother's report of the boy's functioning or request his foster care records. When asked why the boy had not been included in the family treatment plan she created or why she did not develop a plan to ensure his safety in the home, the therapist said she felt it was unnecessary to work with the boy because if she was able to help the mother, that would in turn be beneficial to the son. The therapist stated she had difficulty developing a complete understanding of the mother's situation because the mother had missed many of their appointments. A review of the case file found the mother had not attended two of the sixteen scheduled meetings while the therapist herself had missed three. Neither the family mental health assessment nor the treatment plan contained in the file had been signed by the mother to confirm she understood the contents of the documents. Counseling notes were cursory and provided scant tangible information. The therapist stated she compiled minimal notes so that if patients asked to read their files they would not be upset by the contents. The therapist's supervisor approved all of the therapist's determinations without conducting an objective review of her conclusions or raising questions as to the thoroughness of her efforts.

In her interview with the OIG, the supervisor explained the agency's system for assigning children for counseling services and stated the majority of them enter with a diagnosis of Reactive Attachment Disorder (RAD). RAD is a controversial diagnosis that has not been validated by extensive research or a systematic collection of tangible data. Diagnoses of RAD are frequently made based on theory, anecdotes or extrapolations from laboratory observations of humans and animals. Long-term longitudinal studies on the outcomes of children diagnosed with RAD have not been conducted. RAD diagnoses are often misapplied as an array of non-specific and far-ranging symptoms to satisfy its criteria and overlap with many other conditions. The OIG has encountered two cases in which the RAD diagnosis was misapplied, which served to shield abusive caretakers.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The private agency should discipline the therapist and her supervisor for their mishandling of the family's assessment, treatment planning and counseling services.

A redacted copy of the report was shared with the agency. The Inspector General met with agency Administrators and a member of the agency's Board of Directors to discuss the findings and recommendations made in the report. The therapist and supervisor were disciplined.

2. To best meet the clinical needs of children and families, Intact Family Procedures should require a case conference be convened as part of the clinical provider's family assessment process to discuss treatment needs identified in the Department's Integrated Assessment. The case conference should include all service providers involved with the family and involved extended family members.

The Practice and Procedural memo has been reviewed and revisions have been made. The memo is scheduled to be distributed to staff in December 2007.

3. The Department's Guardianship Administrator should identify and review all wards with a current diagnosis of Reactive Attachment Disorder and develop and implement a plan to determine whether these children and youth were properly diagnosed and are receiving appropriate treatment or whether they require an evaluation that follows recommended guidelines of the American Academy of Child and Adolescent Psychiatry, and the American Professional Society on the Abuse of Children. The OIG will provide the Guardianship Administrator with the two investigations where RAD was misused.

The Department's Clinical Division will review all wards with a current diagnosis of Reactive Attachment Disorder.

GENERAL INVESTIGATION 3

ALLEGATION

A 14 year-old boy accidentally shot his 15 year-old friend while handling a gun in his family's home. Department personnel did not conduct a thorough investigation of the incident or adequately assess the boy's safety in the home.

INVESTIGATION

The family had an extensive history of involvement with the Department dating back over a decade, which included an incident when the then nine year-old boy discharged a gun into a wall in the family's home. At the time, it was learned the boy's father possessed a large array of firearms and that the parents were lax in their efforts to restrict their son's access to the weapons. The incident resulted in an indicated finding of Risk of Physical Harm against the mother for failing to properly secure the gun after the boy fired it, as he was able to retrieve it again later the same night and slept with it under his mattress.

Following the shooting of the friend, the 14 year-old was taken into protective custody and a child protection investigation was opened based on allegations of Wounds by Neglect and Risk of Physical Injury. The supervisor of the investigation had performed the same function with another worker during the the previous shooting incident. Although the investigator performed a Child Abuse and Neglect Tracking System (CANTS) check which showed seven indicated reports against the parents, no information pertaining to the incidents themselves was included in the case file. Despite the supervisor's familiarity with the family's history, he did not share with the investigator his knowledge that the boy had previously fired a gun in the home or review the prior investigation. He also did not instruct the investigator to conduct such a review or to speak with the workers who had handled that case. The investigator did not visit the home to observe how the guns were stored or the measures the parents took to secure them. He did not obtain a copy of the police report to ascertain what police found when they arrived at the scene but instead relied upon the parents' report that they had taken adequate steps to ensure the firearms could not be accessed. The investigator also did not interview the 14 year-old or review his personal history, which would have shown the boy had a history of behavioral problems and depression and had made suicidal threats with such frequency that his parents considered them routine. The boy had previously told a child welfare worker that he wished to speak with a counselor but that his parents would not act upon his requests.

In an interview with the OIG, the supervisor stated that the case was properly handled as a criminal and delinquency matter, as evidenced by the fact the boy was arrested and charged with Unlawful Discharge of a Firearm. The supervisor also felt the 15 year-old's injury was not the result of a blatant disregard of parental responsibility since the mother and father were unaware the youth were playing with a gun at the time of the shooting. The investigator and supervisor's ultimate decision that the boy was not at risk in the home was based on a determination that he was old enough to defend himself from possible physical abuse by his parents rather than an assessment of his safety while living in a home filled with a multitude of easily accessible weapons. The child protection manager who approved unbounding the report failed to adequately review the work performed by the investigator and his supervisor. During the course of the OIG's investigation, all involved child protection staff cited the excessive volume of cases handled by their field office as having a negative impact on their ability to devote the amount of time required to ensure thorough investigation of allegations.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

- 1. The Department's legislative liaison should pursue legislative amendment to Illinois Statute 430 ILCS 65/4-65/10 Public Safety to address the need to revoke firearm registration of parents who demonstrate an inability to keep their firearms from minors under a set of conditions that include: minors, age 16 and under, with a mental condition or behavior that poses clear and present danger to self or other persons (e.g., discharging firearms in the absence of parental**

supervision, shooting guns at other persons, taking weapons or ammunition to school).

The Department believes that any legislation to amend Illinois Statute 430 ILCS 66/4-65/10 should be negotiated by the Illinois State Police and the Department of Natural Resources. The Department of Children and Family Services has no involvement in firearms law.

OIG Response: The OIG is pursuing the legislative change.

2. The child protection investigator should be disciplined for his failure to investigate this case, mitigated by the fact that his caseload was above B.H. limits.

The employee was issued a written reprimand.

3. The child protection supervisor should be disciplined for his failure to supervise the investigator and ensure an informed and adequate investigation of this case. Discipline should be mitigated by the fact that the supervisor was supervising an investigator whose caseload was above B.H. limits. For at least six months, the Department should randomly monitor investigations performed under the supervisor to determine whether he requires additional training.

The supervisor was disciplined.

4. The child protection manager should be disciplined for her failure to ensure an investigation of reported allegations was completed prior to her approval. Discipline should be mitigated by the fact that the volume of investigations in the area was above B.H. limits at the time of this investigation.

The employee received a counseling session.

GENERAL INVESTIGATION 4

ALLEGATION

The developmentally delayed mother of an infant boy who was removed from her custody was not appropriately informed of her parental rights or provided with adequate information and assistance to explore options for his care.

INVESTIGATION

The mother, an undocumented immigrant whose primary language was Spanish, had previously relinquished custody of her six year-old son who had been born prematurely and presented medical complexities. At the time of her first son's birth, it was determined the mother was unable to care for him because of his enhanced needs as well as her developmental delays, unemployment, homelessness and lack of familial support. The boy was placed in the care of a licensed foster mother, who was also a Department supervisor, who later obtained subsidized guardianship. She later allowed her foster parent license to lapse.

Upon the birth of the mother's second child a hotline report was made alleging she would also be unable to care for the newborn. The child protection investigator assigned to the case immediately identified the older brother's foster mother as a potential placement for the baby. On four separate occasions workers attempted to screen the case into court only to be denied by the State's Attorney's Office because the Department could not support its contention that the mother was incapable of caring for her child at present. The investigator did not inform the mother that she retained full rights of the baby since the screenings had failed. The mother, who at the time was living in a homeless shelter, inquired about having the infant placed with a friend who was active in the church she attended and with whom she had developed a bond. The investigator dismissed the mother's request and pursued the former foster mother as the only viable placement. The investigator also failed to assess the mother's ability to keep her child with her at the shelter, even after being informed by staff that she would be permitted to live there with her child for a period of time.

Throughout the time decisions were being made regarding the baby's placement, involved workers relied upon evaluations of the mother performed at the time of her first child's case. In many respects the conclusions drawn were outdated and did not reflect advances the mother had made since that time. As such, they did not provide an accurate portrayal of her ability to parent her second child. Although the case had been opened for intact family services, every effort was made in the interest of placing the baby with someone other than the mother. In addition, a document prepared by the intact supervisor and signed by the foster mother bestowed short-term guardianship of the baby to the former foster mother for one year, despite the fact the statute only allowed such appointments to be made for a period of sixty days. Furthermore, the document was written in English and presented to the mother for signature by the intact supervisor. Not only was the mother made to sign a document she was unable to read, the terms of the agreement itself were out of compliance with Department rules.

Guardianship of the baby was transferred to the former foster mother, whose case continued to be handled by the Department despite her long-standing professional relationship with the intact supervisor and other colleagues involved with the case. Although the intact supervisor raised the issue of her work on the case being a conflict of interest, the Department administrator she reported to assured her she could continue her involvement, as she did not believe a conflict existed. After the administrator later decided a conflict did in fact exist, the case was transferred to a private agency, however the intact supervisor continued to participate in the decision-making process. The influence of Department personnel over the case was exerted when the former foster mother contacted a Department administrator, whom she had known professionally for over 20 years, to complain about what she believed to be unfavorable treatment by the private agency. The administrator intervened to ensure a conflict regarding medical care of the baby was resolved in a manner favorable to the former foster mother, to the detriment of the mother.

It was not until the mother finally voiced her objections and confusion to an intact worker at the private agency that the Department began to fulfill its obligation to examine the possibility of allowing the mother and her child to remain together. The mother fell out of compliance with the requirements of the intact program and was reported to have returned to her home country. Private guardianship of the baby was subsequently awarded to the former foster mother.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The child protection investigator should receive non-disciplinary counseling from the child protection regional administrator for failing to notify the mother of her parental rights and should receive training on screening a case with the State's Attorney's Office. A redacted copy of this report should be reviewed with the investigator during the counseling session.

A "non-disciplinary" counseling was given to the employee.

2. The intact services manager should receive non-disciplinary counseling from the child protection regional administrator on conflict issues, including transferring cases. A redacted copy of this report should be reviewed with the manager during the counseling session.

A "non-disciplinary" counseling was given to the employee.

3. The intact family services supervisor should receive non-disciplinary counseling from the child protection regional administrator for her failure to provide intact family services and appropriate behavior when transferring a case because of a conflict. The intact supervisor should also receive training on the appointment of short-term guardianship as it relates to the Illinois Compiled Statutes, 755 ILCS 5/11-5.4. A redacted copy of this report should be reviewed with the intact supervisor during the counseling session.

Non-disciplinary counseling was completed.

4. The Department administrator should receive disciplinary counseling from her supervisor for her failure to discharge her duties and failure to recognize a conflict of interest. A redacted copy of this report should be reviewed with the coordinator during the counseling session.

The employee received counseling and a redacted copy of the report was discussed with the employee.

5. The intact supervisor should be disciplined for violating the Burgos Consent Decree by having the mother sign the *Appointment of Short-term Guardianship* form written in English.

The supervisor received disciplinary counseling and "non-disciplinary counseling." The supervisor also received one-on-one training regarding Short-term Guardianship.

6. The Department should develop protocol for advising developmentally delayed clients of their rights.

The DD Administrator submitted a draft of the proposed protocol advising DD clients of their rights to the Division of Clinical Services and Professional Development on November 1, 2007. The draft is currently being reviewed and revised. Targeted completion date: December 2007.

7. The Department should develop a specialized intact family team with experience and expertise in working with developmentally disabled parents. In the alternative, the Department should provide

intact family workers with training on working with parents with developmental delays.

The web-based training on working with individuals with developmental disabilities is being developed by Western Illinois University. Target completion date: December 2007.

8. The Department's Division of Legal Services should draft a standardized form for the appointment of Short-term Guardianship and provide training on proper use of the form.

DCFS Legal has assigned an attorney to develop training on the appropriate use of the statutory Short-term Guardianship form.

GENERAL INVESTIGATION 5

ALLEGATION

An adoptive mother continued to accept adoption subsidy payments for a daughter who had left her home and forged medical documents pertaining to the girl and two other children in her care.

INVESTIGATION

The 20 year-old adoptive daughter was placed in the adoptive mother's home in a foster care placement and resided with her for 6 years. After the girl left the home and moved in with her boyfriend and his mother, the adoptive mother continued to accept adoption subsidies for the girl. Eight months after the girl's departure, the adoptive mother signed a form attesting that the girl still lived with her and remained her financial responsibility. The adoptive mother received \$1247 per month for the girl, an enhanced amount based on the girl's medical needs, including treatment for sickle cell anemia. The girl's condition required regular monitoring by medical professionals, however the adoptive mother's failure to ensure the girl received necessary care was identified as a problem while she was in the adoptive mother's home as a foster child. Following her move, the girl's required medical appointments were neglected.

In an interview with the OIG, the girl stated she had received minimal financial assistance from the adoptive mother since leaving her home, a total of approximately \$900. The girl said she had asked her former caseworker to intervene since she was in need of money. The caseworker mediated an agreement with the adoptive mother to provide a check for \$600 to the girl, however the adoptive mother stopped payment on the check after it was delivered. In her interview with the OIG, the adoptive mother acknowledged continuing to accept adoption subsidy payments for the girl after she left her home and withholding financial support from her. She also confirmed she had stopped payment on the check following making the agreement with the caseworker. The adoptive mother stated she had provided some cash assistance to the girl but was unable to provide any documentation to support her claim. The adoptive mother stated she was unwilling to provide the girl with funds because she disapproved of her living with her boyfriend.

An OIG review of the adoptive mother's licensing file found four suspect medical forms pertaining to current and former members of the household. Signatures attributed to the two treating physicians had striking similarities to each other and all resembled the adoptive mother's signature. One of the physicians employed the adoptive mother as a nurse. Both doctors attested to the OIG that they had not treated the patients and that the signatures affixed to the documents were not theirs.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Placement Clearance Desk should be instructed to place an involuntary hold on the foster mother's foster care license.

The Department agrees and the Director approved.

2. The private agency holding the foster mother's foster care license should initiate enforcement proceedings against the foster mother based on her submitting a false affidavit in support of adoption subsidy payments and submitting falsified medical forms for her foster care license.

The Department agrees and the Director approved.

3. The OIG will submit the falsified adoption subsidy statement and the falsified medical forms for possible criminal prosecution.

The Department agrees and the Director approved.

GENERAL INVESTIGATION 6

ALLEGATION

The case of an eight year-old girl remained open with a private agency for four years without advancing towards permanency. Private agency staff failed to familiarize themselves with available permanency options for the girl or adequately assess her living situation.

INVESTIGATION

The girl was taken into protective custody when she was four years old after being passed between numerous family friends following her mother's incarceration. She was placed in the home of her maternal great-grandmother who also cared for three young adopted children. The great-grandmother was willing to assist the girl's mother in pursuing reunification but if the mother could not regain custody, the great-grandmother's permanency choice was adoption. The girl's mother made no attempt to work towards reunification following her release and the girl's father could not be located. The private agency supported a permanency goal of subsidized guardianship even though the girl was not eligible for subsidized private guardianship as a result of her inclusion in a statewide research project studying alternatives to long-term custody. Private agency staff neglected to inquire into the girl's eligibility status for this permanency goal and managed the case as one headed towards subsidized guardianship. The prospect of the great-grandmother adopting the girl was never presented as a permanency option by agency staff.

Throughout the time the private agency was responsible for the case, agency staff demonstrated an inability to develop a cohesive plan for the girl's long-term care or even familiarize themselves with the facts of her living environment. A high volume of turnover among workers, poor communication among staff and substandard preparation of case records and documents all contributed to the inadequate handling of the girl's case. After both the girl's caseworker and the worker's supervisor resigned from the agency, visits to the great-grandmother's home became sporadic and often never took place. An agency program manager assumed temporary responsibility for the case, however she did not review the appropriateness of the guardianship goal or objectively assess the feasibility of the great-grandmother as a caregiver. Although the great-grandmother had eight adult children who frequently visited her home to help with the children, no family meeting was ever conducted nor was a back-up care plan constructed. During a visit, the program manager learned the great-grandmother's adult son lived in the home, but she did not conduct a background check on him as required.

The agency supervisor who oversaw the girl's new caseworker failed to ensure the worker completed assignments, further impeding any potential progress towards permanency. Upon that caseworker's departure from the agency, the supervisor did not ensure the case record contained updated and accurate information. Although at one point it was learned the great-grandmother recently had three toes amputated as a result of complications from diabetes and had to walk with a cane, no additional information was sought regarding her health and no assessment was made of the impact her physical condition might have on her role as a caretaker. In court testimony, the supervisor stated the girl's case had passed adoption screening, even though that had not yet occurred. The supervisor also testified that the girl was the only child living in the great-grandmother's home. After being informed of the great-grandmother's three adoptive children, the supervisor was told by the family the children had moved to another state to live with relatives. The supervisor never determined the reason for the children's re-location, their new address or identified their new caregivers.

Ultimately, the great-grandmother agreed to proceed towards adoption, however the girl's adoption subsidy packet was rejected because an abundance of errors were present in the document. As the great-grandmother's health deteriorated, the girl was moved to the care of her maternal aunt and back-up caregiver pending legal screening and approval of her adoption subsidy.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The private agency program manager should be disciplined in accordance with the agency's personnel policies and procedures.

The Office of the Inspector General shared a redacted copy of the report with the private agency. The Inspector General met with agency Administrators and a member of the agency's Board of Directors to discuss the findings and recommendations made in the report. The employee is no longer employed by the private agency.

2. The private agency needs to ensure that its workers are competently and fully informing families on permanency options.

The private agency has implemented procedures to make sure that all direct staff employees are competently informing families of their permanency options. The agency has instituted a new procedure which will require that all cases are staffed prior to making a recommendation to court to change a goal from return home to another permanency option. This process will assist workers appropriately planning for a family by carefully reviewing the dynamics of the case before a critical decision is made. In addition to the internal case staffing, every worker will be required to attend the training offered by DCFS Office of Legal Services. The training is intended to fully equip workers with the necessary knowledge about permanency planning.

3. The private agency should ensure that workers do not rule out adoption without adequate documentation.

The private agency understands the importance of documentation to support adoption or change. Through a new review process, training and quality assurance initiative the agency will aggressively take corrective action steps to ensure professional and quality documentation regarding goal changes occurs. The agency will enforce the use of internal forms and external DCFS forms to fully capture "Best Practice."

4. The Department's Agency Performance Monitor for the private agency should carefully review case records of foster children for completeness and accuracy to ensure proper permanency goals are established and that permanency planning activities are implemented when the child becomes eligible.

The Department utilized Integrated Assessment and Administrative Case Reviews. A new Permanency tracking tool has also been developed that will address this issue.

5. The Department should require Administrative Case Reviewers to check the Control Group List whenever Subsidized Guardianship is a potential permanency option.

The ACR system has developed a new program which will identify each child via the face sheet on the Case Review Administrative Packet in one of the following categories: (1) This child is NOT eligible for Subsidized Guardianship (Control Group) (2) This child is eligible for Subsidized Guardianship (Experimental Group) (3) This child is currently not assigned to either Subsidized Guardianship Group. The case reviewer will be instructed on the scope and purpose of each category. The Case Review Administrative Packet is used by the reviewer during the course of the case review meeting. This upgrade to the ACR system and changes to the packet will assist the case reviewer in identifying the child's status as related to the subsidized guardianship project and ensure that children not eligible for the subsidized guardianship waiver have the appropriate permanency goal assigned.

6. A redacted copy of this report should be shared with the private agency supervisor's current employer. The new private agency should assess the supervisor's ability to supervise cases with consideration given her lack of case knowledge and the deficiencies in her court testimony in the girl's case.

A redacted copy of the report was shared with the private agency.

7. The Inspector General will send a letter to the Cook County Public Guardian, alerting him to the problem presented in this case, and asking that he remind his assistants to check the Control Group list whenever Subsidized Guardianship is a potential permanency option.

The Inspector General shared her concerns with the Cook County Public Guardian.

GENERAL INVESTIGATION 7

ALLEGATION

During a court hearing, a Department caseworker falsely reported that she had conducted visits with a severely disabled 20 year-old female ward. The caseworker also received reimbursements for travel that never occurred.

INVESTIGATION

For a period of two years the caseworker was assigned to monitor the ward, who exhibited extreme medical complexities as well as extraordinary physical and developmental delays. Although the girl had been living in the same residential facility for nine years at the time the caseworker assumed management responsibility, the worker was based in the girl's hometown, approximately 200 miles away. An OIG review of the case record found that of eight visits documented by the caseworker over a one-year period, the notes for seven were entered on the same day. All seven entries consisted of an identical single sentence referencing the girl's limited functioning. In her interview with the OIG, the caseworker maintained she had conducted her required visits, but did not speak to any caretakers or staff and would stay only long enough to look at the girl because she found the facility "depressing." During this time period, the caseworker submitted travel vouchers seeking reimbursement for the accrued cost of 13 trips to the facility, totaling over \$2,000.

The facility where the girl was placed was populated with numerous staff members and access was closely monitored, as residents required extensive assistance and intervention. Staff interviewed by the OIG could recall only one occasion when the caseworker had visited prior to the OIG's involvement. For each of her visits, the worker claimed to have arrived during the early to mid-afternoon, when residents are in school. All visitors to the school are required to sign in, however there was no record of the worker's presence at the school recorded in the log. Following her first interview with the OIG, the caseworker made a confirmed trip to the school accompanied by a co-worker.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should discipline the caseworker up to and including discharge for the lack of services she provided to her client, for failure to visit and for falsification of records in claiming travel expenses for trips that she did not make.

The Department is pursuing discharge.

2. The caseworker should be required to reimburse the Department for the travel expenses she claimed except for the two trips she did make. A total of \$1,174.96 should be reimbursed.

The Department is seeking reimbursement.

3. The Guardian's office should evaluate whether the girl's medical record should contain a "Do Not Resuscitate" order. This report should be shared with the Guardian's office.

The Guardian's office consulted with the child's physician, and was informed that a DNR order would not be appropriate. The doctor was provided with the DCFS DNR Policy for future reference.

4. If the pediatric nursing facility is more than a hundred miles from the case manager's home office, and no other case management issues necessitate assignment of a case manager at such a distance, the Department should transfer the case management to an office near the facility.

Recommendation will be implemented into practice. The involved case has been transferred to a worker at the field office closest to the nursing care facility.

GENERAL INVESTIGATION 8

ALLEGATION

A Department employee falsified information in order to procure Department funds, which she then provided to her family and friends.

INVESTIGATION

The Department's Vouchering Division noticed irregularities in several vouchers and submitted them to the OIG for investigation. The vouchers in question, which are numbered and allotted for particular staff members, had all been assigned to a single employee. The OIG conducted a review of voucher requests submitted by the employee after being alerted to concerns regarding their authenticity. The OIG examined eight forms submitted to procure 30-day public transit passes to enable clients to access services provided by the Department. Each voucher was issued in the amount of \$75. For each of the requests, the children named and the Child and Youth Identification System (CYCIS) numbers provided for them did not correspond. In most cases either one or both elements were entirely manufactured. In addition, the individuals listed as recipients of the vouchers were not recognized as Department-approved recipients.

One of the recipients was identified as the employee's daughter. The OIG referred the investigation to law enforcement for criminal prosecution.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

- 1. The Department employee should be terminated as an employee of the Department because of misconduct and theft of Department funds.**

The employee is currently on extended leave.

GENERAL INVESTIGATION 9

ALLEGATION

A Department supervisor attempted to use her position and provided false information to police in an effort to circumvent a traffic citation.

INVESTIGATION

The vehicle driven by the supervisor was stopped by a police officer after the officer clocked the supervisor traveling 14 miles per hour over the speed limit. The supervisor engaged in conversation with the officer, requesting that she overlook the offense as a matter of professional courtesy as the Department often works in conjunction with local law enforcement. The supervisor further explained she was rushing back to her workplace in response to an emergency call regarding a Sudden Infant Death Syndrome (SIDS)-related fatality and suggested police assistance might be required to investigate the case. The supervisor also requested the officer's name, stating, "I want to remember your name, so if we were to have a case or even work together."

Later the same afternoon, the supervisor contacted the local Chief of Police and left a voicemail message requesting his intervention in the matter. She again asked for leniency based on her assertion she had been speeding in response to the report of a SIDS death and criticized the officer for failing to recognize the circumstances mitigating her transgression. The police department's Deputy Chief later contacted the supervisor and inquired whether she wished to file a complaint against the officer, but the supervisor stated she did not want to pursue that action. In an interview with the OIG, the Deputy Chief said the supervisor asked again whether anything could be done about the ticket and insinuated the citation would adversely affect the relationship between the Department and local police.

The OIG interviewed the Department supervisor's superior who stated there had been no SIDS-related cases assigned to the supervisor's team on the day in question or during the surrounding time period. An OIG review of investigations assigned to the supervisor's team during the two-week period covering the date of the incident confirmed the superior's report. The OIG also reviewed a copy of the message left by the supervisor for the Chief of Police. In her own interview with the OIG, the child protection supervisor acknowledged asking the officer who issued the ticket for a "break" but denied contacting the Police Chief or ever mentioning anything regarding a SIDS case to any law enforcement personnel.

An OIG review of the supervisor's email records identified dozens of communications sent by the supervisor to friends and family members regarding matters unrelated to Department business. In her interview with the OIG, the supervisor acknowledged reading and signing Department Administrative Procedure 20, which governs approved and appropriate use of communication systems.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

- 1. The Department should pursue discharge of the child protection supervisor.**

The Department is pursuing discharge.

GENERAL INVESTIGATION 10

ALLEGATION

A Department worker was simultaneously employed by a residential facility and performed his functions for the facility during hours he was required to perform his duties for the Department.

INVESTIGATION

During the course of another investigation, the OIG attempted to obtain expense reports, itineraries and travel vouchers pertaining to the worker's Department duties. After learning no such documents existed, the OIG conducted an interview with the worker who confirmed he had a second job at the residential facility. The worker stated his time management enabled him to perform the responsibilities of both jobs without compromising his performance for either organization. A review of time sheets found significant overlap between the times he purported to be at either location. Furthermore, given the distance between the job sites, many of the worker's claims of his presence at either location would be physically impossible. Because of the absence of required documentation, the OIG was unable to verify that a majority of duties essential to his position with the Department had been performed.

In her interview with the OIG, the worker's supervisor stated the worker had previously made passing mention of his part-time employment with another organization but she was not aware of the extent of his outside responsibilities. The supervisor did not personally confirm the worker's job responsibilities were being met but relied upon his assertions they were and accepted his self-reports of time he claimed to be working "in the field." The supervisor stated she had to accept what workers told her because there was no other means of verifying they completed their duties. Although the worker's inability to complete tasks within an acceptable time frame had been noted during previous performance evaluations, she did not question his present compliance, even though she was aware he had also enrolled in a weekend educational program.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department worker should be disciplined up to and including discharge. The OIG will refer the worker to the Department's Office of Child Welfare Employee Licensing for an investigation to determine whether he violated Rule 412 Child Welfare Employee Licensure.

Employee was discharged. The OIG submitted a complaint to CWEL.

2. The worker's supervisor should be counseled for failing to provide adequate supervision to the worker and for not addressing the lack of documentation and accountability for hours worked away from the office.

Employee received a suspension.

GENERAL INVESTIGATION 11

ALLEGATION

A Department employee used her position to obtain confidential information regarding a pending child protection investigation and provided it to the subject of the investigation, with whom she had a personal relationship.

INVESTIGATION

The Department employee, a member of a congregation whose clergy was being investigated for allegations of abuse, contacted the child protection investigator assigned to the case by telephone. The employee identified herself as a fellow worker and asked questions about the investigative process. During the conversation the employee expressed her certainty of the subject's innocence, at which point the investigator terminated the conversation. The investigator continued her work on the case, ultimately submitting a recommendation that the charges against the subject be unfounded.

While the final determination of the case was pending, the investigator received multiple phone calls from the subject, who claimed he was aware the charges against him had been unfounded and requested documentation to verify this conclusion. The investigator's supervisor eventually contacted the subject who stated he was in possession of Department materials supporting his belief he had been exonerated. The supervisor asked the subject to fax her the documents in question and received two printouts related to the case obtained from the State Automated Child Welfare System (SACWIS), a database containing confidential information which can only be accessed by child welfare professionals. A week after the conversation with the subject, the supervisor discussed the case at a meeting with other workers. A co-worker mentioned receiving a call inquiring about the case from the same Department employee who had previously contacted the investigator asking him to define a term listed on the SACWIS printout that had been shared with the subject.

In an interview with the OIG, the Department employee acknowledged contacting the investigator and others in order to learn the status of the case while the investigation was ongoing, as well as providing the subject with the information obtained from SACWIS. The employee stated she did not believe at the time that her behavior constituted a breach of confidentiality since she was giving the information she procured to the subject of the investigation. The employee told the OIG that she understood her actions could have negative ramifications for the Department if the recommended finding was not accepted, and that by operating in conjunction with the subject of a child abuse investigation she might undermine public confidence in the Department.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

- 1. The Department should discipline the employee for violating Confidentiality Rule 431.**

The employee was given a suspension.

GENERAL INVESTIGATION 12

ALLEGATION

A child protection investigator accepted an offer for secondary employment from a mother she had previously investigated for child neglect.

INVESTIGATION

The child protection investigator's involvement with the family began after she was assigned to investigate an allegation of risk of harm and neglect regarding the mother's two children, ages seven and nine, following the return of their father to the family home. After conducting separate interviews with the parents, both children and school personnel as well as reviewing an order of protection the mother had previously filed against the father, the investigator determined the case should be unfounded. The investigator's decision was based on the denials by all family members of any domestic violence issues in the home, despite the fact collateral contacts had reported the mother had previously disclosed domestic violence to them.

Two weeks after the report was unfounded the mother invited the investigator to a lunch meeting and offered her a position as a sales representative for the company the mother worked for. The investigator accepted and began serving as an independent sales representative operating within a unit overseen by the mother, who received a percentage of the total sales. In an interview with the OIG, the mother stated she had been impressed with the investigator's demeanor and dedication and believed those attributes would translate well to a sales position. The mother said she did not inform the investigator of the reason for the meeting prior to her arrival at lunch.

In her interview with the OIG, the investigator stated she did not perceive that working for the subject of a prior investigation constituted a conflict of interest because the report against the mother had been unfounded and the work was conducted on her personal time away from Department offices. The investigator said she consulted the Department's Employee Handbook and concluded the circumstances of her relationship to the mother would not prohibit her from taking the position. The investigator stated she also reviewed Department Rules and Procedures but was not familiar with Rule 437 governing conflicts of interest. Rule 437 requires notification of a supervisor if a worker's secondary employment might affect or appear to affect their official duties or adversely impact the public's confidence in the integrity of the Department. The investigator said she did not inform her supervisor of her secondary employment working for the mother because she, "did not believe it to be an issue."

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should receive ethics counseling for having lunch with a former client and failing to inform her supervisor of her secondary employment and its potential for a conflict of interest.

The Office of the Inspector General conducted counseling.

2. The child protection investigator should discontinue her employment with the company under the direction of the mother as the appearance of a conflict of interest still remains.

The employee was directed to cease her secondary employment.

3. In the event the hotline is called concerning either the mother or father, the child protection investigator should not be assigned to the investigation.

This has been discussed with the Regional Administrator and management staff. Information was also shared with the hotline.

GENERAL INVESTIGATION 13

ALLEGATION

A private agency caseworker misrepresented himself as a Department investigator in order to obtain confidential information about a case involving possible sexual abuse of the daughter of a female acquaintance.

INVESTIGATION

The caseworker learned of the alleged abuse from the girl's mother, who attended the same church. The caseworker then contacted the physician who had examined the girl and presented himself as a child protection investigator employed by the Department. The physician provided the caseworker with confidential information she had obtained during the examination. When the mother and daughter returned to the doctor's office for a follow-up visit, the physician learned the caseworker was a member of the family's church. The physician then contacted the caseworker and questioned him as to why he had requested confidential information about a case in which he had no involvement. The caseworker stated that as a mandated reporter, it was his responsibility to determine if a hotline report was required. The physician, also a mandated reporter, told the caseworker she was aware of the responsibilities related to allegations of possible abuse and would have made a hotline call if she believed it had been warranted.

In an interview with the OIG, the caseworker stated he had received permission from the mother to contact the doctor about the case. The caseworker said he identified himself as a Department employee because, "that is what [his] child welfare license states." The caseworker confirmed he was aware that medical personnel are mandated reporters and that, as a friend of the family with no professional involvement with the case, he was not authorized to request or receive confidential patient information. In a separate interview, the caseworker's supervisor denied ever speaking with him about the allegation of abuse of the girl or instructing him to contact the physician.

A review of the caseworker's personnel file conducted during the OIG investigation found several discrepancies between the caseworker's characterization of his educational history and the transcripts submitted by the institutions he had attended, which were located in a foreign country. Although the private agency had requested an analysis of the caseworker's education prior to his hiring to determine if he met requirements to hold his position, agency staff misinterpreted the findings. Furthermore, the Department's Office of Child Welfare Employee Licensing (CWEL) relied upon the private agency's conclusion the caseworker had fulfilled the necessary educational requirements and did not independently obtain copies of transcripts or diplomas directly from the institutions. A thorough review of the caseworker's academic history found he had achieved the equivalent of a high school diploma through his previous coursework and not the bachelor's degree required to hold his position.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

- 1. The OIG will refer the caseworker to CWEL for an investigation to determine whether he presents a pattern of misrepresentation that warrants revocation of his child**

welfare employee license. The referral will include a complaint against the caseworker received by the OIG during the course of this investigation.

The employee surrendered his CWEL.

- 2. The Department should ensure that CWEL has an established practice of academic credential verification of individuals, and verification of accreditation status of unfamiliar post-secondary schools.**

The Department agrees and the Office of Training and Professional Development has revised the system for granting Child Welfare Employee Licenses. In addition to having applications reviewed by the CWEL

Coordinator, the CWEL Program Manager is reviewing all license applications to ensure all elements of the application are intact and accurate, including the foreign transcript equivalency evaluation, transcripts, and background checks. No applicant is granted a CWEL until the Program Manager has reviewed the applicant's file. This provides a check and balance to ensure details are not overlooked.

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

The Inspector General's Office shared a redacted copy of this report with the private agency.

GENERAL INVESTIGATION 14

ALLEGATION

A 20 year-old male ward was placed in a community integrated living arrangement (CILA) down the street from the home of the Department caseworker handling his case. When the caseworker learned the client was living close to her home, the caseworker requested the ward be moved to another placement.

INVESTIGATION

The caseworker requested the placement change believing she was at risk of potential harm from the ward and stated that it was "possible" that the ward was aware of where she lived. The caseworker cited the young man's diagnosed schizophrenia and developmental delays as reasons for her concern. Although the ward had a history of arrests for minor offenses, such as petty theft and pulling a fire alarm at his school, he had no convictions and there was no evidence to suggest he was violent or harbored any ill feelings toward the worker.

The caseworker sent an e-mail request to an entire line of Department supervisors at once, requesting the ward be moved immediately. In an attempt to comply with the caseworker's request, some supervisors forwarded the email further up the Department's chain of command. No coordinated plan was developed, no assessment was made on the impact of such a decision on the ward, and none of the parties involved noted the caseworker's conflict of interest. One of the recipients of the email, a Department administrator, instructed the director of the private agency that operated the CILA to move the ward immediately. The agency director complied with the administrator's directive and transferred the ward to another facility, one week after the caseworker made her initial request. Due to the request to move the ward immediately, and contrary to the agency's usual practice, the ward did not transition into his new placement.

Following his transfer, the ward's conduct deteriorated, which resulted in yet another move because of risk to the staff. Approximately eight weeks later the ward was psychiatrically hospitalized. Ten days after being released from care, he was arrested for criminal trespass after returning to the facility he had most recently been removed from and refusing to leave.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The caseworker should be replaced as the boy's worker.

The case was closed from DCFS in June 2006 and is now being serviced by DHS CILA.

2. Procedures for Child And Youth Investment Teams (CAYIT) should be amended to include situations in which a move is requested for any reason other than a ward's best interests.

The CAYIT Policy is currently under review. Target completion date: February 28, 2008.

3. This report should be shared with upper-level Department management as a training tool to assist in developing a protocol for identifying conflicts of interest and developing a coordinated management response to email or other requests for changes in case management.

A copy of the report was provided to the Office of Training. It is being incorporated into Fundamentals of Exemplary Management and Supervision, which is scheduled to be delivered in January 2008. It is being incorporated into all pre-service training that will be completed and ready for delivery by December 31, 2007.

4. The Department should expand the Conflict of Interest Committee to include representatives from Clinical, Field Operations and Service Intervention. A representative from each division should be chosen by their respective Deputy Directors to serve on the Committee.

Clinical, Field Operations, Service Intervention, and Office of Employee Services have provided a resource person for the Conflict of Interest Committee to utilize when needed.

GENERAL INVESTIGATION 15

ALLEGATION

A child protection investigator made romantic overtures towards a mother who was the subject of an open investigation.

INVESTIGATION

The child protection investigator was assigned to a case involving the mother, the subject of a report alleging risk of harm to her 13 year-old son. Following a meeting with the investigator in her home, the mother reported the investigator had made repeated comments she felt were suggestive and inappropriate. In an interview with the OIG, the mother stated that during the visit the investigator invited her to sit down with him on her bed and attempted to give her a massage because she appeared “stressed.” After the mother rebuked the investigator for his behavior he left the home, but he later called and explained his departure by saying he, “had to leave before something happened.” The mother also related an occasion when she spotted the investigator sitting in his vehicle outside her home and showed the OIG text messages he had sent her, including one delivered late at night in which he wrote, “I’m still thinking about U.” The mother stated she was hesitant to report the investigator’s actions because she feared he might use his position and influence to have her children removed from her custody.

In his interview with the OIG, the child protection investigator acknowledged sitting on the mother’s bed during the home visit but stated he did not recall whether he had placed his hands on her back and shoulders. The investigator explained the text messages by characterizing himself as a “caring person” but admitted he had never sent text messages to other clients while conducting investigations.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

- 1. The Department should discharge the child protection investigator.**

The employee resigned with no reinstatement with the Department. The employee surrendered his child welfare license.

GENERAL INVESTIGATION 16

ALLEGATION

A Department caseworker worked for a private agency during the hours she was scheduled to perform her duties for the Department.

INVESTIGATION

The caseworker had held the position with the private agency prior to being hired by the Department but did not disclose her employment status at that time. The caseworker remained in the employ of the private agency after her job with the Department commenced and did not inform her supervisor or any other member of the Department administration of her outside employment. An OIG review of the caseworker’s records from both jobs found that for the vast majority of the two-and-a half year period she was employed by both organizations, her work schedules almost entirely overlapped. Time sheets from both organizations, signed by the caseworker, placed her in both locations simultaneously throughout the time period. Although the worker eventually requested and was granted flextime scheduling by the Department, her hours of employment still conflicted with those of her other job. In an interview with the OIG, the caseworker’s Department supervisor stated she frequently encountered difficulty when attempting to contact the worker in the field and had trouble obtaining itineraries from her.

In her interview with the OIG, the caseworker stated she had viewed Department timesheets as an administrative necessity rather than a “solid” representation of when she performed her duties. The worker said she had fulfilled her obligations to both organizations by working additional hours that were not reflected in her employment records.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should discharge the caseworker.

The employee resigned.

GENERAL INVESTIGATION 17

ALLEGATION

A Department administrator who also worked as an independent travel agent arranged a trip for five members of a child protection team and their supervisor, placing an inordinate burden on other staff to compensate for their absence. In addition, the administrator signed a document verifying the supervisor's presence in the office on the day the group left for their vacation.

INVESTIGATION

The Department administrator sold a weekend vacation trip to five members of the same child protection team. In her position, the administrator was part of the hierarchy responsible for the work performed by the team. The team's supervisor, who participated in the trip, approved team members' use of either vacation or comp time in order to miss a day of work to depart for the vacation. In her interview with the OIG, the supervisor stated she did not believe it was accurate to say an entire team was absent from the office because the workers shared responsibilities with colleagues from another team they had been paired with in the Department's organizational structure. A review of the supervisor's time sheets found she had certified that she was present in the field office on the day the group departed for their vacation. Following her interview with the OIG, the supervisor made a request with the Department's payroll liaison to modify her timekeeping record, saying she needed to make a correction. The supervisor amended the record to show she had utilized vacation time to account for the day the group left on the trip.

Both the administrator and the supervisor demonstrated poor judgment and a lack of consideration for the needs of their colleagues and the clients they serve by permitting the team to be simultaneously absent from the field office. Furthermore, after previously certifying she had been present at work, the supervisor attempted to obscure the truth through her attempt to retroactively alter the record to show she had used a vacation day for a known absence.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

- 1. The supervisor should receive discipline up to and including discharge for falsifying her time records and for attempting to alter the records following her interview with the OIG and for failure to cooperate with the OIG.**

The Department is pursuing discharge.

- 2. The Department administrator should be disciplined for signing off on the falsified time records.**

The employee resigned.

- 3. Access to timekeeping records should be limited to timekeeping personnel and should be maintained in a locked file cabinet.**

The Department agrees. Bar locks have been installed on the timekeeper's file cabinets. The Payroll file cabinets are in an office and storage room that are locked when not in use.

GENERAL INVESTIGATION 18

ALLEGATION

A Department employee had previously been convicted of Attempted Murder, an offense prohibiting him from working in the child welfare field. The employee had misrepresented his criminal history to the Department on multiple occasions.

INVESTIGATION

The OIG became aware of the employee's criminal background during the routine execution of duties related to a claim brought by the employee against a co-worker. The OIG learned the employee had an extensive criminal history including convictions for Theft, Firearm Possession, Domestic Assault and Attempted Murder. Upon being hired 13 years earlier, the employee had failed to disclose his background. After the Department learned of his omission he was dismissed, but was permitted to return to his job after he informed his then supervisor that he had been pardoned for the Attempted Murder conviction, a barred offense under the Child Care Act that would prevent him from holding a position in the child welfare field. The employee produced documentation he claimed supported his claim and no further action was taken to address the accusation he had falsified his employment application. Three years later the subject was revisited, however the employee again supplied documents he purported showed his most serious convictions had been overturned and stated the other crimes for which he had been convicted occurred when he was a minor or had simply been arrests. The employee was discharged from his position but was subsequently reinstated following a suspension.

An OIG review of the documents provided by the employee and underlying police reports found he had misrepresented the facts of his criminal past. His Attempted Murder conviction had never been overturned and stemmed from his act of shooting at the face of a 15 year-old girl. The other offenses for which he had been convicted had not taken place when he was a juvenile but occurred over an extended period of time after he had reached the age of majority. The failure of the Department to conduct either a critical review of evidence provided by the employee or a thorough, independent investigation of his criminal history allowed him to remain in his position despite being legally prohibited from doing so.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

- 1. The employee must be discharged for having a conviction that is a barred offense and should be placed on administrative leave pending discharge.**

The employee was discharged.

GENERAL INVESTIGATION 19

ALLEGATION

The OIG received a complaint that Spanish-speaking callers to the State Central Register (SCR) were not receiving the same priority as English-speaking callers and that SCR administration failed to fill open call floor workers' positions with Spanish-speaking staff.

INVESTIGATION

Current SCR policy was outlined in an email dated March 27, 2007, from the Administrator of the State Central Register, in which she asked that staff be reminded that, "... if there are no bi-lingual Spanish speaking staff on duty at the Hotline that they would be expected to process Spanish speaking calls in the same rotation as they would any other calls, only using the Language line for translation assistance. Spanish speaking calls are not to just be put on hold until it is presumed a Spanish speaking Call Floor worker will be available to process the call." An SCR training schedule made reference to the "Foreign Language Line", but did not provide detail. The *Call Floor Manual* stated the importance of noting the primary language of the subjects of reports, especially if the language spoken was not English.

The OIG found that while current SCR policy outlined the procedure to utilize the Language Line for translation assistance when bilingual SCR personnel are not available, it does not differentiate practices for emergency and non-emergency callers. The current policy also focuses only on Spanish speaking callers rather than on any caller whose primary language is not English.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The SCR *Call Floor Manual* should be reviewed for accuracy and cultural sensitivity, and revised to conform to the SCR policy outlined in the e-mail dated March 27, 2007.

A draft of the cultural sensitivity section will be completed by December 1, 2007.

2. SCR staff should participate in remedial training related to working with non-English speaking callers.

The language line training will be completed by December 31, 2007.

GENERAL INVESTIGATION 20

ALLEGATION

During a separate investigation, questions arose regarding immigration services provided to undocumented immigrant wards of the state.

INVESTIGATION

OIG investigations of two cases involving foreign-born wards illustrated several critical problems with services provided to immigrant youth. One case identified concerns related to the utilization of family members as translators, unequal access to education and the use of illicitly obtained social security numbers. The second case revealed a lack of familiarity among both caseworkers and foreign-born wards with the adjustment of immigration status process, resulting in the absence of informed consent for wards.

OIG investigators reviewed 64 active files with the Department’s Immigration Services Unit. The unit is responsible for working with the United States Citizenship and Immigration Services (USCIS) to ensure that the immigration service needs of Department wards are met. The unit is staffed by the Immigration Services Coordinator in Springfield and supervised by the Assistant Guardian in Chicago. The unit is primarily responsible for obtaining lawful permanent resident status for undocumented wards through the adjustment of status process, commonly referred to as Special Immigrant Juvenile Status (SIJS). Should the child meet federal eligibility requirements, the unit and case manager assist the undocumented ward in petitioning the USCIS for SIJS. Once SIJS is granted, the ward is eligible to apply for Lawful Permanent Residency (LPR). Without LPR status, the child remains ineligible for a social security number, which is a barrier to receiving public aid, adoption subsidies, a driver’s license, and financial aid for post-secondary education.

There is currently no formal communication within the Department to ensure the Social Security Administration Application for a Social Security Card (SS-5) forms are completed for children who were recently granted lawful permanent residency. A review of Procedure 327, Guardianship Services, Appendix F – Immigration/Legalization Services for Children with Undocumented Status (Appendix F), intended to provide staff with information and instruction about the status adjustment process, revealed obsolete references and inconsistencies between written procedure and current practice. Policy Guide 2004.02, Mexican Consulate Notification of Mexican or Mexican-American Minors in the Custody of the Department, contained language conflicting with the Department’s form, Notification to Mexican Consulate (CFS 1000-6). CFS 1000-6 also contained outdated instruction to child protection workers, which resulted in few notices being forwarded to the Mexican Consulate.

Sixty-one percent of the children serviced by the unit emigrated from Spanish-speaking countries. Eighty percent of children referred for immigration services reside in Cook County and collar counties. The Burgos Coordinator is also headquartered in Chicago, yet the Department’s immigration expert is located in Springfield and there currently is no service or referral coordination between the Burgos Coordinator and the Immigration Services Coordinator. No formal tracking system currently exists to alert the Immigration Services Coordinator when a child would be eligible to apply for naturalization (U.S. citizenship). The Department can assist wards with the naturalization process and associated fees, provided the ward is age 18 years or older, has had LPR status for at least five years and desires to be a U.S. citizen.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

- 1. The Department should authorize the Immigration Services Coordinator to have “read-only” access to view SACWIS. Access to SACWIS would provide the Unit with current**

information about a child’s living arrangements, court status, service plan, caseworker, and the integrated assessment.

The coordinator received "Read Only" access.

2. The Department should ensure the Immigration Services Coordinator has all available resources to enable provision of direct guidance to wards and workers.

The Department agrees.

3. The Department should revise Procedure 327, Guardianship Services, Appendix F – Immigration/Legalization Services for Children with Undocumented Status to reflect current practices. Because of the complexity and unfamiliar nature of immigration services to child welfare staff, the Department should develop a resource link on the D-Net to provide workers with a central location for obtaining needed information/instruction. There should be communication within the Department regarding the development of computerized/satellite training to reflect current practices of the Immigration Services Unit.

Final draft of Procedure 327 Appendix F has been provided to the Inspector General's Office for review.

4. The Immigration Services Unit's referral form should be revised to include information about the child's employment history and current employment needs and be approved as an official Department CFS form.

The Special Immigrant Juvenile Referral form was issued in June 2007 and is available on DCFS templates. It includes information regarding the child's employment history.

5. Given that timely identification of undocumented wards who may be eligible for status adjustment with the USCIS is necessary to ensure future service delivery and continued best interest:

The Immigration Services Unit should re-implement the tracking process/data base for all referrals received;

Questions regarding a child's citizenship status should be added to the Client Service Plan (hard copy and SACWIS). Proposed changes to the Client Service Plan are as follows:

"Current Goal"

After "Child's Name:" add: "Is child a US Citizen? Yes No"

If yes, the worker can proceed to Reason for Goal.

If no, the following prompt will appear: "Immigration Status:" A drop down box will provide the following options: "Permanent Resident, Refugee, Asylee, Undocumented."

After the immigration status, add: "Has a referral been made to the Immigration Services Unit? Yes No"

The Immigration Services Unit currently has a tracking database for all referrals received but it does not provide tickler alerts. The Inspector General's Office provided a database via disc, which they developed during their review of the Immigration Services Unit. The disc was provided to the Immigrations Services Coordinator and she will incorporate with the existing database. All referrals received are being entered into the database provided by the Inspector General's Office.

The Immigration Alert was distributed in June 2005 on the D-Net.

Adjustments have been made to SACWIS, which may be overly broad. The Deputy Director is reviewing

with Legal Counsel and the Attorney General's Office.

6. A majority of children receiving assistance from the Immigration Services Unit originate from Spanish-speaking countries. The Inspector General recommends referral coordination between the Burgos Unit and Immigration Services Unit.

The Burgos Coordinator will provide the Immigration "Alert" document to workers who 1) contact Burgos for services and 2) have an open child case for a ward who is foreign born.

7. Given that obtaining a child's birth certificate through a foreign consul/embassy is an unfamiliar process to most caseworkers, the Immigration Services Unit should expand its duties to assist caseworkers with this task regardless of the child's goal. Immigration Services Unit personnel have special knowledge of working with foreign consuls/embassies. Should the child's goal change from Return Home, the caseworker would have the necessary documentation to facilitate an SIJS petition.

The Inspector General's Office is reviewing the draft of Procedures 327, Appendix F.

8. The Department should consider developing a Street Law educational model for undocumented and foreign-born wards in need of immigration services.

In conjunction with the Inspector General's Office, a Street Law educational model was developed and training was conducted in April 2007.

9. A redacted copy of this report should be shared with the agency Director. The agency Director should consider discipline for an employee that violated Illinois state law requiring compulsory education of children up to the age of 17 (105ILCS 5/261) showing evidence of bias. The Director should ensure that the employee documents her work efforts.

The Inspector General's Office shared a redacted copy of this report with the agency Director. The employee received discipline.

10. The Deputy Director of the Division of Service Intervention should issue a communication to all Department regional educational advisors instructing them of their obligation to provide educational advocacy for foreign-born wards.

The Communication was sent in November 2006.

GENERAL INVESTIGATION 21

ALLEGATION

An 18 year-old girl and her 13 year-old brother returned to the home of their mother on their own accord after having been placed in the relative foster home of their maternal aunt and uncle. The children's caseworker failed to inform the court of the children's change in residence despite being aware they had returned home.

INVESTIGATION

Although the boy was born in the United States, his mother and sister were undocumented residents. The children's father had remained in the family's country of origin. The children had been removed from their mother's home four years earlier following a suicide attempt by the girl. The mother had not complied with her daughter's physical and therapeutic aftercare plan following the suicide attempt and maintained involvement with a man who had previously sexually abused the girl. The children were placed in the home of their maternal aunt, who lived with her husband and their 12 year-old daughter, and the family's case was assigned to a private agency for services.

The family's case was one of the first handled by the caseworker, who had recently been hired by the agency. One month prior to her involvement, court ordered visitations were granted to the mother, permitting the children to reside with her on weekends. The mother lived in the same apartment complex as the foster parents. Soon after accepting the case, the worker became aware of ongoing hostilities among several of the family members that further strained the already stressful dynamic. The girl had a contentious relationship with her aunt, characterized by frequent conflicts and verbal confrontations.

At one point, the private agency sought to license the mother of a friend of the girl's in order to utilize the woman as an alternative placement, however the friend's mother later terminated the application process. The boy's relationship with the foster parents, while not as combative as the girl's, was also uneven and marked by tension. Both children attributed the rancor to the poor relationship between their mother and the aunt. The foster parents frequently asked the agency to have the siblings removed from their home in the wake of fights with the children, but rescinded the requests after they had calmed down. The foster parents never made a formal request to have the children removed from the home. In an interview with the OIG, the caseworker's supervisor stated the agency had considered moving the children but could not identify any other relatives able to care for them or locate a placement that would allow the siblings to remain together or in their current school. She also cited how the proximity of the mother's home facilitated the overnight visits as a factor in leaving the children in the home.

As a result of the tumult in the foster home, the children frequently began staying with their mother during the week. Although the caseworker received reports the children had moved back in with their mother and repeatedly located them there during unannounced visits, she did not report her suspicions to her supervisor. Additionally, a review of the case record found one occasion when the caseworker had noted the boy's bed in the foster home did not appear to have been slept in and another occasion when she called the mother and asked her to bring the boy to the foster home for a scheduled meeting. Although the caseworker had encouraged the family to comply with the court-ordered visitation and placement schedule, she did not inform the court of her knowledge the children had moved in with their mother during a hearing, one-month after she became aware of their change in status. When questioned by the judge at a subsequent hearing why she had not previously informed the court of this development, the caseworker responded that she did not share the information because she had not been called to testify.

As an undocumented resident, the girl had petitioned for Special Immigrant Juvenile Status based on her permanency goal being changed from return home to independence. After it was learned the girl had moved back in with her mother, her Special Immigration Juvenile Status petition was withdrawn, preventing her from

continuing her efforts to obtain legal employment or pursue federal loans for college. In an interview with the OIG, the girl stated she had signed the petition seeking special status, but that the caseworker had merely told her what it was and had not reviewed the document with her. The girl currently resides in an independent living program and her Special Immigration Juvenile Status petition was granted. The boy was returned to his mother's custody.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

- 1. The private agency should discipline the caseworker for failing to inform the court in a timely manner that the girl had returned home.**

The Inspector General's Office met with the private agency to discuss the report and recommendations. The employee is no longer employed at the private agency.

- 2. The private agency should discipline the caseworker's supervisor for failing to adequately supervise the caseworker.**

The Inspector General's Office met with the private agency to discuss the report and recommendations. The private agency supervisor received oral counseling.

- 3. A mental health agency involved with the girl should consider using the family considered as an alternative foster placement as a possible resource for the girl.**

The Inspector General met with the agency and discussed the report.

- 4. The Public Guardian should reconsider filing the Special Immigrant Juvenile Status petition given the lack of informed consent and the girl's changed circumstances.**

The I-360 was filed with USCIS and approved in June 2007.

GENERAL INVESTIGATION 22

ALLEGATION

An intact services worker refused to assist a 16 year-old female ward seeking to terminate her pregnancy because the practice conflicted with the worker's personal beliefs.

INVESTIGATION

The 16 year-old, the mother of two young children, was found to be pregnant during an initial health screening after being taken into department custody. The girl had been removed from the home of her grandmother, who had adopted her, after the woman's health deteriorated past the point where she could care for the girl and her children. The girl informed the homemaker who accompanied her to the medical appointment that she wanted to terminate the pregnancy and the homemaker in turn informed the assigned intact family services worker the same day.

The intact worker documented the developments in the case record and complied with a request for information from a worker with the Teen Parent Support Network (TPSN). During their interaction, the intact worker told the TPSN worker that she would be unable to assist the girl in terminating the pregnancy because she objected to the practice on religious grounds. The intact worker said she would pass along a phone number provided for an organization that counsels pregnant teens. In an interview with the OIG, the intact worker stated she informed her supervisor that she would not be able to participate in planning or accessing the procedure, however, in a separate interview, the supervisor contradicted the intact worker and said she was never aware the worker was experiencing problems servicing the case. None of the involved child welfare professionals took proactive measures to ensure the girl received comprehensive counseling or medical evaluation to ensure the pregnancy was proceeding normally.

Illinois law requires health care providers to advise pregnant minors of all treatment options. Department rules call for minors entering care to receive a Comprehensive Health Evaluation (CHE) within 21 days of being taken into custody. The girl did not receive her CHE until after 69 days had passed. The CHE performed did not include an ultrasound and her medical records contained in the case file were incomplete and failed to include thorough documentation of the pre-natal care she received. The girl ultimately delivered the baby at full-term by cesarean section. The girl and her children were placed in an approved placement with a family friend and continue to receive services through a private agency.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency handling the girl's case and the Department should amend the HealthWorks contract to ensure that at the Initial Health Screenings, if a pregnancy is confirmed, an obstetrical ultrasound is performed to confirm that the pregnancy is in the uterus and to estimate the gestational age of the fetus, and that a health professional advises and counsels the youth regarding pregnancy options.

The Department will notify HealthWorks that a Comprehensive Health Evaluation and ultrasound must be completed within 7 days when pregnancy is known or suspected. The Department will notify the HealthWorks Lead Agency for Cook Count regarding completing a CHE for pregnant wards within 7 days and doing a pregnancy test at a CHE if pregnancy is suspected. Wards who are pregnant will be referred to an OB/GYN, whose medical judgment will dictate the need for an ultrasound. Notification will be sent by November 2007.

OIG Response: A pregnant youth who has not received prenatal care must receive an ultrasound within seven days of the confirmation of pregnancy.

2. Pregnant and parenting teen wards placed in specialized foster care should not be excluded from benefiting from direct case management specialty services for this population. The private agency

should ensure that all case management staff and their supervisors receive trainings on adolescent pregnancy, teen parenting and related issues.

Every worker, supervisor and administrator who provides pregnant or parenting teen services can attend the UCAN specialty training. This training is designed to teach about all the issues centered around providing services to pregnant and parenting teens. Notification of specialty training is provided by email notification system at the time the training is offered. The training is offered 2 times per year to all affiliated service providers, RSP and ASP's. The training consists of fourteen sessions, which includes adolescence pregnancy, teen parenting and related issues as identified. The OIG will notify the private agency of this training.

3. The Teen Parenting Service Network's phone line should be used during regular business hours for child welfare workers to report a teen pregnancy as soon as it becomes known.

The change to the UIR will be added in the Appendix of Rule 331, which is currently being revised.

4. Within 48 hours of receiving notification of a minor's pregnancy, the Teen Parenting Service Network should follow up with the assigned Purchase Of Service (POS) agency to ensure pregnancy options counseling is provided and timely scheduling of medical follow-up for prenatal care is made.

Within 48 hours of receiving notification of minor's pregnancy the networks provide follow up services through their intake department. Workers are instructed to get the youths pre-natal care scheduled immediately. Information on options counseling is provided at this time. To clarify, counties covered by the Teen Parenting Service Network are Cook, Lake, McHenry, Kane, DuPage and Will Counties. They would not be involved in handling teen ward pregnancies outside of these areas.

5. When a child welfare worker believes he/she has an irresolvable personal conflict to service a pregnant minor because of personal values or biases, the worker should be required to immediately notify his/her supervisor to avoid harm to the client. The worker should follow up notification to the supervisor with a written request for recusal from the case.

The Memo was sent to DCP and Operations on August 3, 2007.

6. The Department must monitor and enforce contract compliance of POS agencies with Department contracts to acknowledge and include fathers and paternal family members as an integral part of case management services. Department monitors must ensure that Department Procedures 302: Services Delivered by the Department and its Appendix J: Pregnant and/or Parenting Program is followed.

The Department agrees. A memorandum is being drafted to DCFS and POS staff. Target completion date: December 2007.

7. Because current Procedure 300, Section 300.60 c) *non-custodial parents need not be interviewed unless believed to have information regarding the injury or situation* does not convey the importance of non-custodial parents as sources of information, the OIG recommends that this section of Procedure 300 be amended to state that there is a presumption that involved non-custodial parents have relevant information and therefore should be interviewed during the child protection investigation.

The Department drafted a protocol to address this recommendation.

8. Currently, the Department's Unusual Incident Reporting Form (UIR) has a section – *Type of Incident Checklist* – that includes identification of parenting ward or discovery of a ward's pregnancy should be changed to more clearly communicate the minor's status (pregnant, parent, or both).

The Department agrees to redraft the form.

GENERAL INVESTIGATION 23

ALLEGATION

A situation in which a judge vacated private guardianship and returned children to a parent's care triggered an investigation as to whether any misconduct was involved and whether any legislative changes were necessary.

INVESTIGATION

As a result of physical abuse to one child, siblings were removed from their mother's care and placed with relatives by the Department. Eventually the relatives obtained private guardianship of the children and, requiring no further service from the Department, requested closure of the Department case. Some time later, private guardianship was transferred to another relative.

The biological parent later filed a motion to terminate guardianship. A hearing was held on the matter and the judge determined that although the parent may have been unfit at one time, there was no current evidence of unfitness and therefore, terminated guardianship and returned the children to the parent's care.

A Motion to Reconsider was subsequently filed. Approximately three months later the judge released a written opinion in which the motion was denied and the guardianship terminated as previously ordered.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

The OIG made no recommendations to the Department.

GENERAL INVESTIGATION 24

ALLEGATION

The OIG identified recurring patterns of Department employee's misuse of the email system.

INVESTIGATION

Frequently, during the course of conducting investigations, the OIG is required to review emails sent through the Department's email system. In so doing, the OIG has recognized the repeated and regular presence of emails unrelated to state business and possibly inappropriate in a professional environment. Three common types of emails were identified.

Inspirational messages, while well intentioned, do not contribute to the performance of Department or state business. Some employees have such messages programmed as automatic attachments to all emails they send, an issue that will require additional consideration by the Department. Jokes and other comedic messages might not be appreciated by all recipients and run the risk of creating conflict within the workplace. General announcements heralding goods and services provided by local businesses and agencies are legitimized by their inclusion in Department emails and could be construed as tacit endorsement of the claims made within.

Although many of these messages are initially received from sources outside the Department, when they are forwarded to other employees through the email system they assume a new relevance while subtracting from the overall professionalism of the organization.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The Department should send a clearly stated directive to all employees to cease using e-mails for other than state or Department business and that the Department will not

tolerate improper use of e-mails with state equipment and on state time. The directive should state that e-mails of jokes, poems and inspirational messages are inappropriate and should never be forwarded.

Employees should be advised to inform the senders that such e-mails should not be sent. The Department should advise employees that e-mails from agencies that include solicitation for funds should not be forwarded.

Employees should be reminded that misuse of the e-mail system will result in discipline and the Department must follow through on administering employee discipline when inappropriate e-mails are found.

Misuse of Email was distributed to DCFS staff as an email and also a D-Net announcement on November 16, 2007.

SYSTEMS INVESTIGATIONS

When the Inspector General's Office notices a particularly high level of complaints in a specific area of the child welfare system, the Inspector General's Office will conduct a systemic review of the issue. These reviews, or "Systems Investigations", may also result in recommendations being made. The Systems Investigations conducted in FY 2007 are summarized in this section.

CHILDREN WITH MEDICALLY COMPLEX CONDITIONS

ISSUE

Children who are technologically dependent or otherwise medically complex present unique challenges to the child welfare system, both in terms of identifying neglect and in caring for those who have been neglected. Current laws and professional standards mandate a low threshold for reporting children bearing signs of physical abuse or for whom overtly abusive or negligent parental behavior is observed. However, neglect, particularly of children with complex medical problems is unclear because it is often based on lack of positive findings. Therefore, because of the considerable medical and emotional harms associated with inaccurate diagnosis and reporting of parental neglect, particularly in children with complex medical problems, more stringent standards for diagnosing and investigating situations involving children with complex medical conditions should be considered.

DISCUSSION

In 2005, the Inspector General's Office (OIG) completed an investigation of the Department's handling of a child protection investigation pertaining to allegations of medical neglect, environmental neglect, substantial risk of physical injury/environment injurious to health and welfare, and inadequate food of a medically complex child. The Inspector General's investigation resulted in numerous recommendations relating to children with medically complex conditions. The Director accepted these recommendations in 2005.

Also during the course of the 2005 investigation, the Inspector General's Office requested assistance from the Child Welfare Ethics Advisory Board (the Board) in identifying the ethical considerations that should be taken into account when there is an allegation of medical neglect for a child who is severely medically compromised. The Board suggested the need for a special protocol or procedure for handling allegations of abuse or neglect of severely medically compromised children in home care.

The following year the Board reviewed several more cases involving allegations of medical neglect of children with medically complex conditions. The Board noted that with medically complex children, a determination of neglect may require substantial medical expertise. The Board identified a need for the Department to develop a way of evaluating cases in which abuse or neglect is alleged for children with complex medical needs. The Board suggested developing a list of questions for use by Hotline personnel and investigators, and considering a possible role for expert assistance in investigating the allegations.

Later that year the Board reviewed and discussed preliminary findings collected from data gathered by Inspector General Research Assistants and agreed that the Board would remain involved in the issues involving children with complex medical needs. The Board also reviewed and commented on the draft "Protocol for Children with Medically Complex Conditions" the DCFS workgroup developed.

The OIG conducted a case study involving the death of a 21-month-old child, which illustrated the inherent difficulties when there are discrepant medical opinions. The facts of the case involved a child who, at one month of age, was diagnosed with a heart murmur by her pediatrician and referred to a

cardiologist. She had a pattern of poor weight gain and frequent vomiting, and was hospitalized upon recommendation by her cardiologist to work up suspected failure to thrive. During her seven-day hospitalization the child gained weight, which one of the evaluating physicians interpreted as evidence of a bonding issue between the infant and her mother. At the direction of this physician, a hospital social worker placed a hotline call and an investigation was opened against the infant's mother for non-organic failure to thrive. The child's pediatrician did not agree with this diagnosis based upon a history with the patient and her family. The hospital physician did not believe the parent was meeting the child's needs based on information gathered during a hospital stay. The cardiologist initially documented that the child's failure to thrive was not because of her cardiac status. The differing opinions among providers were not reconciled before the case closing. The mother was indicated, but a handwritten note from the cardiologist dated shortly before the child's death stated that the child's cardiac abnormalities could have caused her failure to thrive.

The Inspector General's Office reviewed in detail the summaries of sixty-six cases compiled by the Research Assistants and determined that the cases fit into three categories: missed medical appointments, missed medications, and not following medical advice. Upon further study of these cases and reflection on the investigations related to children with medically complex conditions, the Inspector General's Office determined that the issue of not following medical advice sometimes involved simple non-compliance with medical advice; other situations involved the complication of conflicting medical opinions, which required a different type of investigation and investigative protocol.

The Inspector General's Office developed and submitted two draft documents to the DCFS workgroup for review. The OIG also reviewed the DCFS draft protocol that had been revised by the Office of Child and Family Policy, and outlined concerns about the differences between the DCFS and OIG draft documents.

**OIG RECOMMENDATIONS /
DEPARTMENT RESPONSES**

1. The OIG and the Department should continue their collaboration in developing a document for medically complex children prior to finalizing proposed Procedures 300, Appendix L, which contains investigation and case management guidelines and procedures for investigating certain allegations.

Additional input is being received regarding children with special healthcare needs. Recommendations from this group will be shared with the Clinical Division of Child & Family Policy.

2. Upon completion, approval or adaptation of the documents on children with complex medical needs, the OIG will support implementation by providing a literature review, redacted reports, and assist in ad hoc training (i.e. management policy education forums).

The Department agrees. The Inspector General's Office has provided redacted reports and teaching tools and will offer additional assistance as requested.

3. The indicated report against the mother of the child who died of severe pulmonary hypertension should be expunged, and the mother notified by letter of this action.

The indicated report was expunged and certified official letter was sent to the mother.

4. The case study should be provided to the Ethics Board, and the Medical and Executive Administrative Staff, of the involved hospital in an effort to inform future practice.

The Inspector General's Office shared a redacted copy of the report with the Ethics Board and the hospital.

ERROR REDUCTION TEAMS PLAN

ISSUE

The Error Reduction Team Legislation, Public Act 95-0527, enacted in 2007, requires the Office of the Inspector General to identify problematic practices or errors in child welfare that compromise or threaten the safety of children, based on analysis of Inspector General death and serious injury investigations and Child Death Review Team Recommendations. To meet the requirements of PA 95-0527, the Office of the Inspector General proposed an Error Reduction Plan, which consists of both training and post-training reinforcement as well as evaluative components.

DISCUSSION

The Initial Error Reduction Plan (the Plan) focuses on errors made in investigations involving Cuts, Welts and Bruises, identifying risk in cases of substance abuse and mental illness, and reducing accidental deaths. The training will begin in FY 2008 in selected counties. Several Inspector General death investigations revealed that many deaths were preceded by unfounded or pending investigations of Cuts, Welts and Bruises. The Cuts, Welts and Bruises allegation is the most common designation of hotline allegations and can range from allegations of a pea-sized bruise to serious physical injury. The Plan consists of training on investigation basics, such as identifying the *who, what, where, when and how* of the injury, techniques to ensure thorough evidence collection and interviewing key informants.

The Risk Identification component of the Plan will focus on use of available tools to identify risk to a child whose parent is seriously mentally ill and/or has issues involving substance abuse. The Plan includes training on confidentiality and on screening cases into court as necessary. As a result of the new legislation (*see* page 154 of this Report), the training will also include screening cases into court for the limited purpose of securing orders of protection to ensure compliance with critical services, like drug treatment or medication compliance.

THE ERT PLAN

I. ERROR REDUCTION TRAININGS

Field Training – General Principles

Trainings will infuse good investigative techniques designed to reduce homicides and accidental deaths into regular practice. The training goal is to impart problem-solving skills for the worker in servicing clients and families. Training should encourage the use of basic management skills applied to identified problems i.e. “these are the areas we want you (manager/supervisor/front line worker) to think about, what are the barriers you encounter to getting this done?” The content must stress the importance of case notes to tell the full story of a case. Training in the field will be in several stages to be staggered over several weeks. Management staff will be trained to provide frontline training to field staff.

Supervisory staff training

The aim of the supervisory training sessions is two-fold: guiding supervisors in teaching error reduction principles to field staff, and equipping the supervisors with the tools to better support their frontline workers. The key concepts of this training include problem-solving, critical thinking, quality assurance issues, creativity, biases, and civility. The training will also address supervisory responsibilities, such as the ability to competently review 72 DCP investigations per month. Questions that the training will assist the supervisor

in answering include: How can you assure that a short cut is safe and appropriate?

Management and Legal Staff Training

The training for management and legal staff is directed toward supporting front line staff and identifying and providing what frontline workers need to competently perform their investigative and casework responsibilities. The training will also address the management of resources, identification of missing resources, and development of outside resources.

Quality Assurance Training

The Inspector General's Office will be available to train up to 6 DCFS Quality Assurance staff on the substance of the ERT Plan; how to monitor compliance with the Plan and reporting requirements; and how to measure outcome of ERT Implementation. Components of the training will include the following:

- conducting statistical analysis of the data
- attending death review teams
- reading cases and relevant material
- identifying numbers of cases by region
- reviewing death investigations

II. TRAINING CONTENT

A. Child Protection Investigations – Allegations of Cuts, Welts and Bruises

A review of death and serious injury investigations conducted by the Inspector General's Office identified key investigative errors in abuse and neglect investigations involving cuts, welts, and bruises. The ERT trainings will address the following deficiencies:

- error of not identifying who, what, where, when, how
- error of over reliance on self reports
- error of confidentiality – myths
- error of lack of scene investigations
- identifying and interviewing key informants
- assistance with scheduling interviews
- accessing relevant information (doctors, subpoenas)
- qualitative record review and investigations
- assuring that relevant information is written in case notes
- noting prior suspicious incidents that were either unfounded or not reported to the hotline

B. Screening a case into court

In a review of the death and serious injury cases, the Inspector General noted common obstacles to screening a case into court. The training sessions will address both subject matter issues and procedural questions related to screening a case into court.

1. Issues

- risk assessment
- reducing bias
- protective orders
- reassessing risk with receipt of new information

- confidentiality
- documentation
- getting full information on substance abuse and mental illness
- recognizing cumulative risk
- recognizing dependency issues and how to screen

2. Procedural questions related to screening a case into court

a. How and when to screen a case

- How to get a case screened into court when the previous investigation was poor or inadequate; the previous investigator either missed facts, or facts were considered in isolation; or the same fact pattern is seen in subsequent sequences
- Identifying circumstances where screening should be considered

b. Practical strategies to get a case screened

- re-interview key contacts
- gather new information
- obtain assistance from the Clinical Division
- request a mental illness specialist
- differences in screening child protection investigation and Intact Family cases

c. Reflecting the thoroughness of the investigation in the investigative notes

- was there a scene investigation?
- was there a thorough interview of collaterals?
- was there a problem solving approach used? (for Intact Family cases)
- inclusion of historical data (for Intact Family cases)

d. Working with the State's Attorney

- present risks identified in a case
- primary documents must be current
- include medical reports
- include psychological evaluations
- present collateral information to verify information suspected or patterns
- present mental illness, domestic violence, substance abuse and the extent to which any of these factors affect parenting

III. POST-TRAINING REINFORCEMENT

Following the field trainings, Quality Assurance personnel will be in the field offices providing support and reinforcement of the trainings to managers, supervisors and frontline staff. The support provided by Quality Assurance will include the following:

- thorough record reading and case consultation through attending weekly team meetings in selected sub-regions (estimated three days per week).
- review all death cases where there was an open or unfounded DCP investigation within the 12 months prior to the death.
- identify and provide hands-on monitoring of all pending investigations involving cuts, welts and bruises to include records review, observation of supervision sessions, recommendations for safety plans and report to OIG concerning findings.
- review and monitor all death cases in which there was an open intact case, and review intact cases

that were closed within the 12 months prior to the death.

- develop charts for each region recording these death with a goal to lower homicides and accidental deaths and demonstrate this through the graphs.
- write quarterly and annual reports to be distributed to the Director, OIG and Management staff.
- review Federal PIP re-abuse data of 7.8% statewide with a goal to drop maltreatment numbers related to deaths. (Object is not only to help communities and regions but also to respond to the Federal PIP.)

IV. REPORTING AND EVALUATION

Quality Assurance will develop a plan for evaluating and reporting progress and compliance. The evaluation plans will include outcome measures, obstacles to implementation, and topics omitted or requiring further training.

OIG RECOMMENDATION/ DEPARTMENT RESPONSE
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The Inspector General's Office recommends that the Department support the implementation of the Error Reduction Plan around the state as necessary to provide a mechanism for sharing practice wisdom learned through the Inspector General's death and serious injury investigations. The Plan would incorporate a critical thinking and problem-solving model to address potential lethal errors.

The Error Reduction Plan was approved.

ADMINISTRATIVE HEARINGS UNIT APPEALS

ISSUE

In 2005, a federal court held that the Department's 75% overturn rate of challenged indicated findings demonstrated a lack of due process protections for persons who were indicated for abuse or neglect and whose livelihood could be affected by an indicated finding. The Office of the Inspector General reviewed decisions of the Administrative Hearings Unit for FY 2006 to review rates of overturned decision in light of the federal judicial decree and to address concerns related to lack of feedback to the field concerning overturned decisions.

DISCUSSION

In its review of the Administrative Hearing Unit's decisions for FY 2006, the Inspector General's Office found that the Administrative Hearings Unit decreased the percentage of overturned appeals by approximately 60%. The Inspector General's Office review did not determine whether the lower indication rate affects child safety and therefore, whether the change is positive or negative. The focus of the review was limited to the rate of overturned indicated findings.

In conducting its review, the OIG noted two recurrent issues that frequently required overturning an indicated finding. First, the definition of an "eligible perpetrator" differs depending on whether the allegation is abuse or neglect. The cases that were overturned at hearing because of an ineligible perpetrator primarily involved allegations of neglect, as opposed to abuse. Under the Abused and Neglected Child Reporting Act (ANCRA) perpetrators of abuse can be a child's "parent or immediate family member, or any person responsible for the child's welfare, or any individual residing in the same home as the child, or a paramour of the child's parent". A perpetrator of neglect must be "responsible for " the child's "welfare"; simply living in the home or being a paramour in the home where neglect occurred, is not enough. Neglect allegations that were indicated against perpetrators without a showing that the person was "responsible" for the care of the child were therefore, overturned on appeal.

Second, in investigating an allegation of sexual abuse or exploitation, a child's statements do not need to be corroborated to indicate a report. However, if the child is unavailable to testify (either because the child is too young or because testifying is determined to be harmful to the child) the child's statements cannot be introduced as evidence in an administrative hearing unless the statements were corroborated. In the appeals granted on the grounds of uncorroborated statements, the indicated findings were based on uncorroborated evidence without medical or physical verification to substantiate the allegation. The Office of the Inspector General also noted a case involving a therapist's testimony in which both the court professionals and the Department showed a lack of understanding of confidentiality.

The OIG investigated whether a feedback loop existed to inform the field about errors that occurred during the child protection investigations that were noted by the Administrative Hearings Unit. The Office of the Inspector General determined that the Department did not have a method for feedback to the field, and to provide training to the field about frequent errors noted on appeal.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should develop a feedback loop that identifies field errors and informs individual child protection investigators, supervisors and managers of the errors.

Management should then evaluate the need for enhanced training in light of the overturned investigation.

A cross training of the Division of Child Protection, the Administrative Hearings Unit, and Office of Legal Services will be arranged.

2. The Administrative Hearings Unit should develop and maintain a summary database that would be available to the field on administrative or judicial review of indicated findings.

If a case is voluntarily unfounded, DCFS Legal will notify the DCP supervisor and explain the reason for unfounding. In addition, DCP will devise a process to get feedback to the field via supervisors/managers to explain and review how or why a decision was made to voluntarily unfound the investigation. If the case is overturned at hearing, the Administrative Hearings Unit will send the supervisor of the team the final decision. In addition, if a case is overturned, the Guardianship Administrator's Office will maintain a database with the basis for overturning the case for DCP to use during their monthly management meetings.

3. The Department should develop objective guidelines for determining when an individual living in the home is a "person responsible for the child's welfare" for purposes of neglect including those referenced in the body of this Report.

Child Protection is currently reviewing Rules and Procedures to determine what information regarding identification of a person(s) responsible for a child's welfare is currently included and/or what information may need to be added.

4. The decision in the transcript regarding a therapist's testimony should be shared with DCFS Legal and the Chief Administrative Law Judge to determine if training is necessary.

The Department will cross train between child protection staff, the Administrative Law Judges, and the Office of Legal Services staff. To date, one cross training has taken place.

CHILD ENDANGERMENT AND RISK ASSESSMENT PROTOCOL (CERAP)

ISSUE

In FY 2006, the Office of the Inspector General issued a report, in conjunction with the University of Chicago School of Social Service Administration, identifying flaws in the current Child Endangerment Risk Assessment Protocol. The issues identified included:

- Failure to develop or monitor a realistic safety plan
- Failure to recognize cumulative risk with substance abuse, domestic violence, and mental illness
- Failure to use multiple sources of information or access available information
- Failure to retrieve or analyze criminal history background
- Failure to consider other adults with access to the child/ren
- Failure of supervisory input

DISCUSSION

Following the issuance of this report, the Director asked the Office of the Inspector General to contribute to the Department's Task Force to identify improvements to the *Child Endangerment Risk Assessment Protocol* [CERAP]. The Office of Inspector General identified limitations of the CERAP tool that was currently in use:

- The CERAP's Risk Assessment questions contained too many modifiers, inviting inconsistent application and lack of reliability;
- The CERAP's Risk Assessment questions do not permit the investigator to note the need to acquire more information before answering;
- Some questions ask for information that is beyond the capability of any investigator, such as whether an identified risk will occur "immediately."

Representatives from the Office of the Inspector General met with the Task Force on several occasions and provided ongoing recommendations. A new draft CERAP was developed that addressed the problem of lack of information by permitting investigators in the initial risk assessment to temporarily leave questions unanswered recognizing the need to gather more information. The new tool also eliminated the use of some of the more problematic modifiers. However, the final CERAP draft that was issued for field-testing introduced concepts of *Safety Thresholds*, which required additional conditions before a risk could be identified. The Inspector General's Office determined that the *Safety Thresholds* were so abstract and poorly defined that their use may result in failure to identify existing threats to safety. As a result, the Inspector General's Office withdrew from the Task Force and offered its concerns and recommendations in a report to the Director.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The new CERAP should eliminate the use of Safety Thresholds and limit the Safety Information Standards to those necessary to good investigative practices.

The Safety Workgroup has developed a new draft CERAP that is currently being field tested. The Safety Workgroup has incorporated recommendations received from the OIG into the process as deemed appropriate to the overall models.

OIG Response: The preliminary field test for the new CERAP suggests that it is cumbersome and may detract from investigators' ability to determine whether abuse or neglect occurred and ensure the safety of the child, because it has too broad of a focus. Rather than centering the investigator's attention on good investigation practice to determine the who, what, when, how and where of an investigation and on developing strong

safety planning-the tool focuses on broad assessment questions that are more appropriate for an Integrated Assessment after an allegation is indicated.

2. The focus of CERAP training should be on conducting solid investigations of the allegations.

CERAP training has to focus not only on safety threats related to allegations, but also on those family dynamics that may impact child safety though not allegation related.

OIG Response: Failure to focus on basic investigative skills can yield sloppy investigations.

INITIATIVES, TRAININGS, AND COLLABORATION INVOLVING OLDER CAREGIVERS

ISSUE

At the request of the DCFS Director, the Inspector General's Office completed an historical perspective on initiatives involving older caregivers.

DISCUSSION

A series of investigations conducted by the Inspector General's Office over the last ten years, coupled with the Department's review of foster homes caring for five or more children, revealed developing problems within the older caregiver population that threatened the safety and permanency of children. In an attempt to resolve these threats, the Inspector General's Office and the Department constructed a life span problem-solving model that blended child welfare and geriatric expertise. In FY 2001 DCFS funded a grant to Metropolitan Family Services to pilot the model, which expanded its services and geographic area over the next five years. The Older Caregiver Project is now providing citywide services. Since its inception, the Older Caregiver Project has served over 210 families, which included over 530 children.

In FY 2004 the OIG developed a training manual, *Kids and Older Caregivers*, for state and private agency child welfare workers and assisted DCFS' training division in incorporating key components of the curriculum into the Department's revised adoption curriculum. The Department on Aging served as co-trainers. Since 2004, over 440 child welfare supervisors, managers and trainers statewide have been trained on the curriculum, and approximately 50 direct child welfare staff received an abbreviated version at adoption trainings. In addition to internal trainings, OIG staff has also presented the essential elements of the lifespan approach to 330 professionals within the aging network and to professional audiences across public services.

In FY 2005, the OIG produced a study on housing problems facing DCFS older caregivers, which revealed increased housing problems for many of the older caregivers who provide care for children in foster care, home of relative care, subsidized adoption and guardianship.

In this same year, following another series of investigations by the OIG and complaints from Officers of the Court, the Department committed to a more formalized review of older caregiver pre-adoptive parents and the identified back-up caregivers. In 2006, the OIG assisted in introducing the *60+ Initiative* in Cook County. The *60+ Initiative* has been introduced statewide, and the OIG has trained more than 120 child welfare supervisors and managers on the initiative.

Recognizing the number of DCFS children who were either adopted or for whom guardianship was obtained by older caregivers, in 2006 the Department entered into a Memorandum of Understanding, which resulted in a one year pilot program administered through the Center for Law and Social Work. The Family Matters Pilot Program, extended in 2007 for another year, provides social work and legal services for selected older and ill caregivers, and the families of recently deceased caregivers.

Throughout the past five years, the OIG has worked collaboratively with various agencies and organizations within the aging network, such as Grandparents Raising Grandchildren Taskforces, Area Agencies on Aging Executive Directors, and the Illinois and Chicago Departments on Aging. These collaborations have resulted in enhanced training and availability of resources, and coordination of services and interventions between departments. Most recently these collaborations resulted in the development of a cross agency brochure for distribution by the Department as well as by any state agencies involved with an older caregiver family.

**OIG RECOMMENDATIONS/
DEPARTMENT RESPONSES**

1. The Department should immediately implement practice changes suggested by the Family Matters Pilot Program including: a) expand post adoption services to provide additional assistance to families in which an adoptive parent or legal guardian dies; b) develop written information about how to implement an identified back-up plan; c) develop resources to complete home studies and interim studies for children in subsidized guardianship, or adoption to subsidized guardianship conversion situations.

The Department agrees.

2. The Department should consider approving the Grandparents and other Relatives Raising Children brochure for use by child welfare staff.

The Department agrees.

OLDER CAREGIVERS ADDENDUM

ISSUE

Staff from the Older Caregiver Training Unit and the Administrator of the Family Matters Pilot program met in an effort to provide consistent information and enhance trainings related to older caregivers.

DISCUSSION

The common practice of older caregivers adding the names of supportive back-up caregivers to the older caregiver's bank account in an effort to ease the eventual transition to the back-up caregiver has the potential for financial exploitation. The Inspector general's staff explored options to decrease this potential. The Illinois Department on Aging (IDOA) Bureau of Elder Rights and the National Adult Protective Services Association (NAPSA) suggested working with banks to explore options of restricted access to caregiver funds to minimize the potential for financial exploitation.

In addition, the Inspector Generals' staff noted that in some subsidized guardianship cases, biological parents have been proposed as back up care providers; in some instances this could be an appropriate plan, but not in other situations. When implementation of a back up plan has a child returning to his/her biological parent, this essentially represents a return home and should be addressed as a reunification with supportive services provided to the parent and children. In such a situation, the subsidy should not continue and the Department should involve either the Juvenile or the Probate Court prior to implementation.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. A representative from Training should regularly update all *Family Matters* and *Kids and Older Caregiver* training content to promote consistency and incorporate new material into regular training curricula.

The Department agrees.

2. When an officer of the court receives *Family Matters* or *Kids and Older Caregiver* training, DCFS Legal should be present to ensure consistent information and coordinated service delivery.

The Department agrees.

3. Training should develop guidelines to ensure that all information given to older caregivers, including information related to financial and health care planning, is consistent with material from Bureau of Elder Rights and the National Adult Protective Services Association.

The Department agrees.

4. When a biological parent is identified as an appropriate long-term option as caregiver of the child and the family desires to implement that option, DCFS Legal should be involved (see recommendation #6), the case should be brought to court, the subsidy should end, and the Department should offer services to ensure the safe and successful permanency of the child's return home. These cases should be incorporated into the Department's statistical count regarding reunification efforts.

The Department agrees.

5. The Subsidized Guardianship Agreement (CFS 1800) should be amended. At a minimum this agreement should allow for payment suspension and termination of the agreement when custody of a minor is restored to a biological parent. In the interest of complete and full disclosure however, the possibility of a child returning to his/her biological parent and the steps necessary for that to occur should be clearly identified in the General Provisions Section of the Agreement.

The Department agrees.

6. In any case in which a change in guardianship essentially represents a return home, DCFS Legal should be involved to ensure that the appropriate petition is filed in the appropriate court and to represent the Department at any subsequent hearing on the matter.

The Department agrees.

SERVICES FOR OLDER CAREGIVERS

ISSUE

Through a legislative initiative the Department of Children and Family Services funded a pilot project that provided social work and legal services to ill or frail elderly caregivers and families of recently deceased caregivers to secure future care and a custody plan for their surviving children. The pilot program included assisting the caregiver in developing a back-up plan for the child in care.

DISCUSSION

In FY 2006, the Department implemented the *60+ Initiative* which required Cook County pre-adoptive parents, ages 60 and older, and identified back-up caregivers to meet with the DCFS Adoption Liaison to review the subsidy, review the back-up plan and discuss the back-up caregiver's role and responsibilities for the child. If the Adoption Liaison identifies concerns regarding either the living arrangement or back up plan, the Liaison refers the family to the Child Protection Mediation Program to assist in resolving the issues. The Department developed a protocol for this review process, training was provided, and the protocol was implemented as part of regular casework practice in Cook County. These mediation services, available only to families with open Juvenile Court cases in Cook County, achieved 100% agreement in the *60+ Initiative* mediations and had capacity for additional referrals. The families that would benefit most from the services available through the pilot program are those whose adoptions were completed years ago.

OIG RECOMMENDATION / DEPARTMENT RESPONSE

1. The pilot project should target those families most in need of their services, such as families whose adoptions were completed before routine practice incorporated back-up planning and mediation for pre-adoptive and pre-guardianship families.

Referrals to this program continue to be entirely from the post adoption older caregivers population

FOSTER HOMES WITH SHARED CASE RESPONSIBILITY

ISSUE

Several death investigations and one licensing investigation involved the practice of two or more agencies having monitoring responsibilities in a single home. Most frequently, one agency (or the Department) has the responsibility for monitoring the foster home license, and may also monitor the placement of a foster child or children in the home and another agency (or the Department) is responsible for monitoring a different foster child in the home.

The Inspector General's investigations identified communication problems and failure to identify contours of shared monitoring that contributed to case management errors. The facts involved in each investigation led to specific recommendations concerning managing cases with shared case responsibility.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should develop guidelines for shared monitoring responsibilities when a single foster home has children monitored by different agencies or when the case monitoring and license monitoring functions are split between agencies. The guidelines should include the following requirements:

- a staffing of all involved case and licensing workers;
- written agreement of roles and responsibilities of each worker;
- written guidelines concerning the responsibility to share information and the process for sharing information.

The Department referred the OIG to current policy (Policy transmittal 2006.07) and the OIG will make recommendations for changes or enhancements to this policy. A mechanism needs to be in place regarding sharing information with multiple agencies, such as conducting a staffing every 6 months, but more often if needed, and all agencies receiving a copy of a UIR involving the home.

OIG Response: The Inspector General's Office prepared specific recommendations to address problems inherent in shared home responsibility. The document provided by the Department does not address those recommendations.

2. The Department should issue a policy memorandum that states that whenever possible, each foster home should have a single entity that monitors placement of foster children and foster home licensing. POS may grant waivers to the policy based on individual children's needs but must ensure that the guidelines stated above are in place whenever a waiver is granted.

See above responses.

3. Whenever a waiver is not granted and case responsibility is transferred to a single agency, the relinquishing agency should not be penalized but be moved up for case rotation assignment of a new case.

See above responses.

4. The Department should ensure that licensing and casework information on SACWIS is available to all licensing workers, caseworkers and their supervisors assigned to a foster home.

See above responses.

EMPLOYEE CONFLICT OF INTEREST

ISSUE

Several investigations conducted by the Inspector General's Office involving employee conflicts of interest demonstrated a need to revise Rule 437, promulgate Procedures for the Rule, and provide training among upper level management about conflicts in general.

OIG RECOMMENDATIONS/ DEPARTMENT RESPONSES

1. A task group should be assembled to revise Rule 437 and draft related Procedures.

A task group was assembled, but is currently in abeyance and the Director is currently reviewing possible changes to Rule 437.

2. Procedural additions should include:

- a. **If an employee takes secondary employment where there is the potential for contact with DCFS clients, a wall needs to be built between the DCFS employee and any DCFS client being serviced by the secondary employer. In this case, the employee's supervisor should call the secondary employer to verify the wall is in place.**
- b. **The supervisor should review secondary employment at the time of the annual review to see if a conflict has developed that was not present when the employee accepted the employment.**
- c. **Instructions on how to contact the Conflict of Interest Committee.**
- d. **All DCFS employees should receive training on the revised Rule and Procedures 437.**

The Director is currently reviewing possible changes to Rule 437.

3. The task group should consider the extent to which private agencies should be included in Rule 437.

The work group is currently in abeyance and the Director is considering the extent to which private agencies should be included in Rule 437, Employee Conflict of Interest. The work group was provided with redacted copies of certain Office of the Inspector General reports.

REFERRALS TO THE OFFICE OF CHILD WELFARE EMPLOYEE LICENSURE

ISSUE

In the year 2000, the General Assembly mandated that the Department of Children and Family Services institute a system for licensing child welfare employees. The employee licensing system that was developed seeks to provide accountability, integrity and honesty from those entrusted with the care of vulnerable children and families. A child welfare license is required for both Department and private agency child welfare and licensing workers and supervisors. The Department, through the Office of Employee Licensure (OCWEL), administers and issues Child Welfare Employee Licenses (CWELs).

DISCUSSION

Although the CWEL system has been in place since 2002, less than 15% of all complaints to OCWEL come from outside the OIG. The Office of the Inspector General has recently become aware of incidents where Department employees were discharged for cause, which would have warranted employee license revocation, but complaints were not made to OCWEL. The most recent situation involved a worker who was discharged for falsifying case records. Approximately fourteen months after discharge this individual was hired by a private agency, once again working with Department wards. It was only at this time, after being hired by the private agency, that the incident was brought for consideration for an employee child welfare license investigation.

OIG RECOMMENDATION / DEPARTMENT RESPONSE

1. The License Administrator from the Office of Child Welfare Employee Licensure (OCWEL) should provide training to staff from the Office of Employee Services on conduct which may constitute a CWEL violation and how to refer such cases to OCWEL.

The Department agrees. Training staff met with the Office of Employee Services and reviewed Rule 412. Office of Employee Services staff have agreed that they will refer any cases that may be a CWEL violation to the CWEL office. The CWEL Office will meet with private agency staff at their quarterly meetings to address this issue.

BIRTH CERTIFICATES

ISSUE

A decision made by the Illinois Department of Public Health to unilaterally deny Department requests for verification of vital records impeded Department workers from performing their duties.

DISCUSSION

In an effort to facilitate cooperation between the Department and DPH, the OIG met with members of DPH administration. DPH administrators expressed concerns that Department employees had been responsible for improper dissemination of vital records information obtained and had misrepresented the reasons for requesting such information. The administrators further contended that Department employees had failed to comply with a memorandum of understanding governing access to vital records information. During the course of the meeting it was ascertained that the objections raised by DPH did not arise from specific instances of improper behavior but were rooted in more general concerns regarding potential problems that might occur and unsubstantiated, anecdotal accounts. The two sides agreed to work together to resolve the issue and further educate employees on the guidelines for requesting and disseminating vital records information.

OIG RECOMMENDATION / DEPARTMENT RESPONSE

1. The Department should issue a memorandum to Department employees and Purchase of Service (POS) agencies that workers should not have foster parents or other individuals procure a vital record when one is needed. Workers or the POS agency should be using the CFS 402 form for such requests, but only after an attempt has been made through the county clerk for the record.

A D-Net announcement was published on January 31, 2007.

2. Form CFS 402 should be revised to include the requestor's name, title, signature and contact number and the date of the request. A section for Purpose of Request should be included and if for court, a space for the docket number of the case.

The revisions to Form CFS 402 have been made.

3. The Department should issue a current copy of the list of the POS agencies contracting with the Department for services for children to the Department of Public Health.

A Purchase of Service Agency listing has been prepared and was shared with Public Health on November 30, 2007.

4. Procedure 302 should be revised to show that certified copies of vital records will be assessed a fee and that the fee on administrative copies of vital records will be waived by the DPH, but not necessarily by the local county clerk. This procedure should also address the issue of prepaid postage.

Language is being drafted that will be submitted to the Office of Child & Family Policy by December 2007.

5. DPH should report any specific instance of breach of confidentiality by a caseworker to the OIG for investigation.

The Department agrees.

6. The Department should arrange a meeting with DPH and the Department of Public Aid to work out the difficulties in securing birth certificates by Department workers, POS agency workers and adoptive parents.

A meeting with DPH is scheduled.

7. The OIG report should be shared with DPH and the Department of Public Aid.

The report was shared.

HOME SAFETY CHECKLIST

ISSUE

The Inspector General's Office investigated Child Protection Service Workers' compliance with completing the Home Safety Checklist and distributing accompanying required literature.

DISCUSSION

In FY 2004 the Inspector General's Office developed and implemented the Home Safety Checklist in response to a review of child deaths and serious injuries from fire and other environmental hazards, and from recommendations made in the 2003 *Child Death Investigations Involving Infants' Sleep Safety Report*. This checklist, administered by Child Protective Services Workers and Intact Workers, was designed to address the top five causes of unintentional death for children in Illinois under the age of 5 years; fire and burns; automobiles; sleeping/suffocation; drowning, and unintentional falls. It also addresses other potential sources of injury to children, including violence. The Department issued three Home Safety Checklists (CFS 2025, CFS 2026, and CFS 2027.) In FY 2006, in response to feedback from the field, the three checklists originally issued were reformatted and the instructions were rewritten to clarify and facilitate the assessment process. Also, distribution of four pieces of safety literature became a required component of the checklist

In order to determine whether the Home Safety Checklist was being completed as part of child protection investigations, the Inspector General's Office conducted a statewide sample of randomly selected indicated investigations involving a child under the age of one year. Eighty percent of the cases reviewed had a completed Home Safety Checklist; twelve percent had checklists waived by supervisors for valid reasons (e.g. protective custody was taken); four percent were not completed because parents refused to sign the checklist; four percent of the investigative files contained no checklist.

A qualitative review of the completed forms revealed that the majority of workers did not complete the checklist according to the instructions. The inconsistencies prompted a revision to the checklist to simplify the form to obtain a more standardized response from workers. Overall, the supervisors and workers who reviewed the modified checklist believed that the form was user-friendly, less cumbersome, more streamlined and efficient, and less confusing than the previous design.

In addition to the qualitative assessment of the checklist, a separate review was conducted of FY 2007 Central Store orders for safety literature to determine ordering patterns by DCFS offices, and the availability of safety literature for investigators. Unannounced visits were also made to four DCFS offices to assess the availability of safety literature, which was noticeably absent from reception areas and visiting rooms. Approximately 90% of the supervisors and managers interviewed about the availability of safety literature at their offices were unable to articulate a clear process for ordering, storing, or maintaining this literature. Overall, supervisors were confused and unfamiliar with how the literature dovetailed with the checklists, as well as when and how to use the safety literature. Supervisors overwhelmingly endorsed the concept of bundling safety literature with the checklist in order to improve distribution.

The Inspector General's Office could not substantiate the allegations that Child Protection Service Workers were not completing the Home Safety Checklist. A closer review of the checklist, coupled with feedback from the field, resulted in a more streamlined and standardized revised checklist. A closer review of the literature disseminated with the checklist resulted in revising the violence prevention brochure and bundling the revised checklist along with the literature.

**OIG RECOMMENDATION /
DEPARTMENT RESPONSE**

1. The Department should reformat the Home Safety Checklist for Child Service Protection Workers (CFS 2027) and the Home Safety Checklist for Intact and Permanency Workers (CFS 2025).

1. Revisions were sent to the Office of Child and Family Policy in November 2007.

OIG INITIATIVES

LEGISLATION

Graduated Sanctions

Several child deaths investigated by the Office of the Inspector General involved intact family cases in which compliance lagged and the Department lacked the ability to affect the parent's behavior or screen the case into court despite mounting concerns for the children's safety. These cases illustrated the need for court assistance and intervention in intact cases where non-compliance with services or a parent's failure to address underlying conditions created risk of harm to children.

Without graduated sanctions, courts do not get involved in cases until it is necessary to remove the children. The use of graduated sanctions recognizes that court intervention may be helpful in motivating a parent to comply with needed services. Graduated sanctions could be successfully utilized in situations in which a child welfare investigation results in an indicated finding of abuse or neglect related to a parent's drug use, alcohol abuse, developmental delay or mental health issues and an intact family case is opened. A parent may have initially cooperated with services, but then compliance declines. Or, a parent may have previously been involved in drug treatment, but has relapsed and has subsequently given birth to a drug-exposed child. These patterns of behavior can pose unreasonable risks to the safety and welfare of the child(ren). Graduated sanctions would require an intact case to be brought into court when non-compliance or non-progress became apparent. Rather than removal of the child from the home, the court would enter a protective order requiring specific actions on the part of the parent. Failure to fulfill those duties would require additional court involvement and enforcement, up to removal of the child from the home. The key to graduated sanctions is that there is a specific treatment plan that is monitored by the court with known consequences. Studies have shown that court monitoring under these circumstances enhances compliance with service plans and therefore increases the likelihood of reunification. Judicial enforcement has a central role in monitoring a parent's treatment progress and compliance with requirements imposing sanctions and rewards as needed.

The Inspector General's Office recommended statutory changes to the Juvenile Court Act that could, in effect, impose graduated sanctions in certain circumstances. The specific amendments concerning abused, neglected, or dependent minors, provide that:

1) if it is determined that a parent's, guardian's, or custodian's compliance with critical services mitigates the necessity for removal of the minor from his or her home, the court may enter an Order of Protection setting forth reasonable conditions of behavior that a parent, guardian, or custodian must observe for a specified period of time, not to exceed 12 months, without a violation; 2) a petition with respect to an alleged abused, neglected, or dependent minor may request that the minor remain in the custody of the parent, guardian, or custodian under an Order of Protection; and 3) if a petition is filed charging a violation of a condition contained in a protective order, and, if the court determines that this violation is of a critical service necessary to the safety and welfare of the minor, the court may proceed to findings and an order for temporary custody.

The recommended statutory changes (HB 0616) were signed into law in August 2007 as Public Act 95-0405, effective June 2008.

Error Reduction Teams

In FY 2007, the Legislature created the DCFS Oversight Legislative Committee in response to newspaper articles featured in the *Belleville News Democrat* suggested that mistakes within the Illinois child welfare system had contributed to the deaths of several children. In March 2007, the Inspector General appeared before the Legislative Committee and provided her concerns. The Inspector General's speech is reprinted below. The Office of the Inspector General analyzed several death investigations and identified the most prevalent errors. The Committee accepted the proposal of the Inspector General's Office to develop training around the identified errors and to create a feedback loop of the lessons learned through OIG death investigations to the field. The legislation that grew from the Oversight Committee requires the Inspector General's Office to develop Error Reduction Plans and submit them to the Director for approval. Once approved, the Inspector General's Office will work with the Department's Division of Training and Development to develop a curriculum for the field. After the training, the field will receive hands-on reinforcement of the training and evaluation of the effectiveness of the reforms through the Department's Quality Assurance Division. The legislation, Public Act 95-0527, passed unanimously and becomes effective in June 2008.

DCFS Inspector General's Remarks to the House Committee on DCFS Oversight

March 8, 2007

Whenever there is a tragic event, such as a fire or car crash where children are killed, we question whether these untimely deaths could have been prevented. When any child is killed by human hands, we search for a way to stop violence. Tragic outcomes may have multiple causes, including the coming together of fatal circumstances or lethal misjudgments and errors.

One of the duties of the Office of Inspector General is to seek out causes to children's deaths when the children have been involved with the State's child welfare system within the preceding twelve months. The purpose of the inquiry is to prevent possible future harm to our children and assure that the child welfare system is faithfully holding true to its duties.

When an initial inquiry into a death suggests misconduct or systemic problems within the child welfare system, the Inspector General's Office conducts a full investigation. These full investigative reports are given to the Director and the Governor. Annually, we produce a report for the Legislature which provides detailed information on investigations and findings, but does not include names.

Before I discuss our investigative child death findings, I would like to take a moment to quickly review the other duties of the Office of Inspector General, since some of these duties are related to State funding of vital child welfare resources.

In the last few years, we have concluded several investigations of financial misconduct, including: over-billing of a half of a million dollars a year by a private contractor; an upper level state manager diverting a quarter of a million dollars into a personal bank account; an unqualified contractor cashing hundreds of thousands of dollars of state checks at a currency exchange with over \$100,000 unaccounted for or spent on personal expenditures, and a state manager diverting tens of thousands of dollars to pay family and friends' mortgages and other personal bills.

Some of these cases have been prosecuted, others are awaiting prosecution. Restitution is always sought. I only mention these cases because it is not only our statutory mandate to investigate misconduct, but because every single dime taken was needed to serve and protect our children and families. When parents who have completed drug treatment and are working hard to live a drug-free lifestyle but, because of a lack of state funds, cannot access affordable housing or the job training resources needed to bring their children home, we have to remember that financial misconduct within the child welfare system means money is lost to programs that serve our families and children. Many poor communities are desperate for adequate resources.

We also have followed our statute by investigating and prosecuting charges to revoke Child Welfare Employee licenses so that unscrupulous individuals do not remain in the position to exploit child welfare agencies.

But back to the subject of our concern, the deaths of those children who had at least one contact with the Department within 12 months of their deaths. Our investigative data informs us that 26% of the children were wards, 17% were children who were the subjects of at least one unfounded child protection investigation and 16% were children who were in homes of their parent(s) while the family was receiving intact family services. Of special concern, the next highest percentage, 9% involved children of wards. I have attached to my testimony the Office of Inspector General's 2000-2007 investigative data that details these figures.

About 50% of the deaths were from natural causes, childhood diseases, illnesses, or birth defects. While the prevention of these deaths may best belong in the hands of public health, sometimes we intervene, if we find that the Department and its contracted agencies may have been able to prevent some of the children's deaths. For example, after we compiled cases of natural deaths, we found that a number of state wards or children of families involved with the Department died during or following an asthma attack. We recommended and worked with the Department to assure that every asthmatic child involved with the Department had an asthma action plan.

About 40% of deaths of the children are from accidents (22%) and homicides (18%). In addition, we examined the 9% of child deaths that have suspicious or undetermined manners of death and 1% that were child suicides.

As to 22% of children who died from accidents, in our 2004 Annual Report, after noticing that a number of the children perished in fires, we targeted fire fatalities. Families served by the Department are more prone to environmental risks of child fire fatalities. Fire tragedies are horrific. One fire incident took three of our foster children, with two of the burned children suffering for a month before their deaths. The foster home the children lived in did not have a working smoke detector. It is a firefighter's nightmare to find the body of a small child hiding from the fire that killed him. The private agency that licensed the home withdrew from providing foster care following the deaths.

Poverty sometimes drives parents to make use of makeshift heating sources that place their families at risk of fire deaths. In one of our investigations, we found a worker believed that a surge protector would protect the home from overheating wires. She also over-relied on a translator to offer heating advice to the parents. The worker was disciplined for her lapses. But, our investigation also pointed out systemic problems: the lack of bilingual professionals and the need to educate workers so they can educate their families on home safety. We need to better anticipate risks.

The present crisis in utility rates has repercussions for child welfare workers that have to ensure that families have adequate and safe heating sources. In addition to poverty-related fire risks, child welfare workers are also expected to be aware of increased risks to families who may be compromised by

substance abuse, needing to secure special precautions to counter risks of home safety while parents attempt recovery.

For the last several years, a firefighter and an investigator with the Cook County Medical Examiner's Office have joined the Inspector General's Office in training child welfare and child protection workers on home and child safety. Local fire departments have assisted the Department in distributing smoke detectors to needy families. Sometimes, change is best done through partnerships, reminding all of us we are in it together, trying to stop tragedies.

The most chilling, if not the most sorrowful child deaths are those brought on by the hands of parents and their partners, or other caretakers. Sometimes, other children or adolescents lethally harmed the victims. Of the 788 child deaths we reviewed over a seven-year period (2000-2007), 141 or 18% were victims of homicide. While some were victims of street crimes, 28% were children who had been the subject of previous unfounded investigations (24) or whose families were receiving intact family services when they were killed (15). Something is strongly amiss in these deaths. What went wrong with child protection investigations or services?

Our investigations into these deaths discovered that there were lethal errors in judgment, inadequate investigations, especially in complex investigations, over-reliance on self-reports of the alleged perpetrators, no juvenile court orders of protection to compel the parents' cooperation with services and a lack of logic testing. In situations where clear and effective guidelines are violated by individual employees, the individual is held culpable for the error and discipline is recommended.

If mitigating circumstances, problematic processes or insufficient resources contributed to the fatalities, we make systemic recommendations. We take lessons from industry and governmental catastrophes, using analytical methods, when human error is not sufficient to explain the lethal event. For example, our analysis of a series of serious injury and death cases examining the Child Endangerment Risk Assessment Protocol (CERAP) used during protective services investigations found that there was a failure to establish and monitor a realistic safety plan for children when there was alleged abusive or violent behaviors, that insufficient information was gathered to make good judgment calls as to the child's safety that individuals' failures were not corrected through supervisory review (while the Department evaluates its CERAP's outcomes over a 60-120 day period, the Inspector General reviews deaths and serious injuries if the Department was involved in the 12 months preceding the fatality). When families were under the monitoring of DCFS, protective orders were not obtained, sometimes because they were not requested; other times, State's Attorney's offices did not screen the case into court. We found that investigative fault lines need to be corrected by supervisors and field managers with targeted training. But, there are critical supervisor and field manager vacancies in some of the offices where there should be targeted corrective actions. For example, in the East St. Louis sub-region, 50% of the supervisor positions are vacant.

A short summary of every child's death meeting the Inspector General's Office criteria for review is included in the annual report for the fiscal year in which the child died. For example, in the current January 2007 Annual Report, there is a summary of every child who died in the fiscal year 2006 (July 1, 2005-June 30, 2006). When a Report to the Director is issued in a child's death, a second summary of the full investigative report is included in the annual report for the fiscal year the report was submitted to the Director. Full investigations are in-depth investigations and may be as long as 20-30 pages. The Full investigation, unlike the short summary, may be pending at the time of the annual report. The timeliness of the Full Report depends on a number of factors, such as the status of subpoenaed documents (hospital, medical examiner reports or mental health records), and interviews scheduled with family members who may be the source of relevant information. Presently, an investigation is pending because family members explained that they were exploring legal options. In other full investigations, we may include a group of

fatalities because of systemic problems. For example, after several initial investigations we produced a Full Report on the cumulative risks to the children of DCFS wards. But, there is always a short report on all children's deaths in the appropriate annual report. Recently, the *Belleville News Democrat* inaccurately stated that the death of a child in April 2002 was not published in the annual report "until 2005, three years after she died." The child's death summary was published in the January 2003 Annual Report.

With regards to the Inspector General's staff, I do not have 21 investigators, contrary to stories in the *Belleville News Democrat*. Our Office has 17 state employees, nine of whom are investigators. Our headcount has been reduced from 23 to 18. We are suffering from staff shortages, leading to delays in investigations. At the time of this year's annual report, we had six full investigations pending. In 2005, because of bureaucratic mazes, it took over a year to fill two investigator vacancies. During that same period, I had two employees on maternity leave. Even as Inspector General, I cannot give a reasonable or rational explanation why I cannot fill an attorney vacancy for almost two years. Our office has no drivers, nor do I wear silk pajamas.

In 2005 I wrote in our annual report that Illinois citizens and our legislators expect child protection investigators and caseworkers to be adequately trained and properly supplied. Ignorance is a poor excuse for a faulty investigation or an ineffective service strategy. Error reduction methods, as well as professional information on children's bruising or accidents and peer review research on effective substance abuse or violence treatments, should flow into the field as needed supplies. If we hold ourselves accountable, but also recognize that we are always in a learning environment, we may be able to lower child fatalities. Thank you for this opportunity to share my thoughts on the Inspector General's findings on the death of children who have had contact with the Department in the 12 months preceding their death.

Denise Kane, Ph.D.
Inspector General

Public Act 095-0527, (in relevant part)
(20 ILCS 505/35.7 new)

Sec. 35.7. Error Reduction Implementations Plans; Inspector General.

(a) The Inspector General of the Department of Children and Family Services shall develop Error Reduction Implementation Plans, as necessary, to remedy patterns of errors or problematic practices that compromise or threaten the safety of children as identified in the DCFS Office of the Inspector General (OIG) death or serious injury investigations and Child Death Review Teams recommendations. The Error Reduction Implementation Plans shall include both training and on-site components. The Inspector General shall submit proposed Error Reduction Implementation Plans to the Director for review. The Director may approve the plans submitted, or approve plans amended by the Office of the Inspector General, taking into consideration policies and procedures that govern the function and performance of any affected frontline staff. The Director shall document the basis for disapproval of any submitted or amended plan. The Department shall deploy Error Reduction Safety Teams to implement the Error Reduction Implementation Plans. The Error Reduction Safety Teams shall be composed of Quality Assurance and Division of Training staff to implement hands-on training and Error Reduction Implementation Plans. The teams shall work in the offices of the Department or of agencies, or both, as required by the Error Reduction Implementation Plans, and shall work to ensure that systems are in place to continue reform efforts after the departure of the teams. The

Director shall develop a method to ensure consistent compliance with any Error Reduction Implementation Plans, the provisions of which shall be incorporated into the plan.

(b) Quality Assurance shall prepare public reports annually detailing the following: the substance of any Error Reduction Implementation Plan approved; any deviations from the Error Reduction Plan; whether adequate staff was available to perform functions necessary to the Error Reduction Implementation Plan, including identification and reporting of any staff needs; other problems noted or barriers to implementing the Error Reduction Implementation Plan; and recommendations for additional training, amendments to rules and procedures, or other systemic reform identified by the teams. Quality Assurance shall work with affected frontline staff to implement provisions of the approved Error Reduction Implementation Plans related to staff function and performance.

(c) The Error Reduction Teams shall implement training and reform protocols through incubating change in each region, Department office, or purchase of service office, as required. The teams shall administer hands-on assistance, supervision, and management while ensuring that the office, region, or agency develops the skills and systems necessary to incorporate changes on a permanent basis. For each Error Reduction Implementation Plan, the Team shall determine whether adequate staff is available to fulfill the Error Reduction Implementation Plan, provide case-by-case supervision to ensure that the plan is implemented, and ensure that management puts systems in place to enable the reforms to continue. Error Reduction Teams shall work with affected frontline staff to ensure that provisions of the approved Error Reduction Implementation Plans relating to staff functions and performance are achieved to effect necessary reforms.

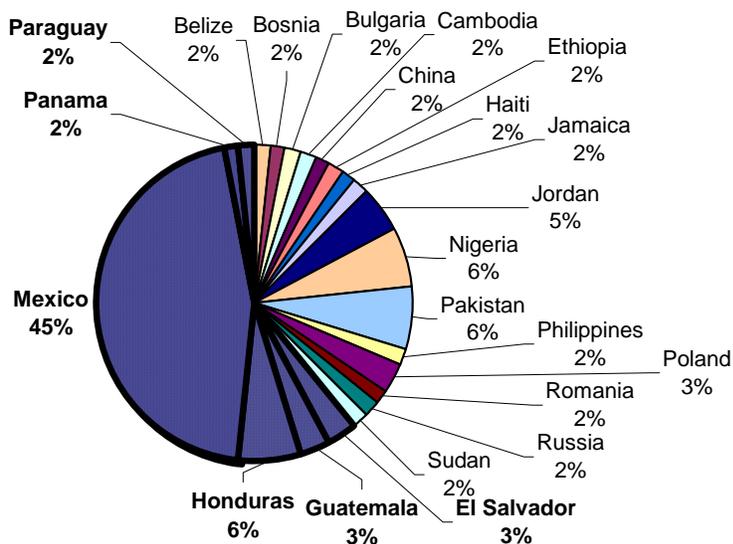
(d) The OIG shall develop and submit new Error Reduction Implementation Plans as necessary. To implement each Error Reduction Implementation Plan, as approved by the Director, the OIG shall work with Quality Assurance members of the Error Reduction Teams designated by the Department. The teams shall be comprised of staff from Quality Assurance and Training. Training shall work with the OIG and with the child death review teams to develop a curriculum to address errors identified that compromise the safety of children. Following the training roll-out, the Teams shall work on-site in identified offices. The Teams shall review and supervise all work relevant to the Error Reduction Implementation Plan. Quality Assurance shall identify outcome measures and track compliance with the training curriculum. Each quarter, Quality Assurance shall prepare a report detailing compliance with the Error Reduction Implementation Plan and alert the Director to staffing needs or other needs to accomplish the goals of the Error Reduction Implementation Plan. The report shall be transmitted to the Director, the OIG, and all management staff involved in the Error Reduction Implementation Plan.

(e) The Director shall review quarterly Quality Assurance reports and determine adherence to the Error Reduction Implementation Plan using criteria and standards developed by the Department.

IMMIGRATION EDUCATION INITIATIVE

The Office of the Inspector General (OIG) conducted two investigations regarding immigration services provided to foreign-born wards under the care of the Department. The investigations underscored the complex needs of the immigrant population and gaps in service provision. One significant gap was that little training had been provided to child welfare staff to inform them of immigration issues affecting clients and services available to foreign-born wards. The investigations also revealed a need to ensure that immigrant youth interacting with the United States Citizenship and Immigration Services (USCIS) were provided with informed consent during the adjustment of status process, were educated about behaviors that could jeopardize immigration status, their responsibilities for maintaining their immigration status, and their educational rights.

Office of the Inspector General investigators reviewed 64 active files with DCFS Immigration Services Unit. Children and youth from 22 different countries of origin were receiving assistance from the Immigration Services Unit. Thirty-nine children referred (61% of the total number of cases) originated from Spanish-speaking countries. Forty-eight children (75% of the total number of cases) were undocumented residents and received assistance in adjustment of immigration status from undocumented resident to Special Immigrant Juvenile Status (SIJS), to Lawful Permanent Resident (LPR). Seventy-six percent of the SIJS children originated from Spanish-speaking countries. The Immigration Services Unit assisted the remaining children/youth in obtaining U.S. citizenship, replacement of permanent resident cards, and adjustment of refugee/asylee status.



Based upon recommendations from the Inspector General reports, the Immigration Education Initiative, a pilot training, was developed to educate immigrant wards and child welfare staff about immigration status, the process of status adjustment, and behaviors that could jeopardize immigration status. The Inspector General's Office and the Immigration Services Unit partnered with Loyola University School of Law to conduct a pilot training on April 19, 2007. The training was conducted in Chicago because eighty

percent of children statewide referred for immigration services reside in Cook County and its collar counties.

As of April 2007, there were thirty-three wards with open Immigration Services Unit files in Cook, Lake, McHenry, Kane, DuPage, and Will counties. The children/youth originated from eleven countries and ranged in age from four to twenty-one. The training was limited to immigrant youth age fourteen and older, because of the complexity of the topic and the requirement by the USCIS that applicants age 14 and over undergo fingerprinting, background check, and sign all USCIS documents. Thirty-eight individuals, including seven youth, participated in the pilot training.

Two concurrent training sessions were designed: one for wards and one for child welfare staff. Separate curricula and materials were developed for each group. An adaptation of a high school educational law model (Street Law) was implemented to fit the needs of the Department's foreign-born youth. Under the direction of an expert in Street Law, two student teachers with personal and professional background in immigration services provided instructional and educational activities to the youth. Both student teachers reflected the majority of the population served by the Immigration Services Unit, as both were Latino and bilingual in English/Spanish. The curriculum created for the youth utilized a timeline as a foundation to explain the process of status adjustment from undocumented resident to citizenship with an emphasis on personal responsibility for completing USCIS forms truthfully. The training educated youth about their educational rights and financial aid resources, depending on their immigration status. Group activities were used to actively engage the youth in the learning process. Training materials provided to the youth were *Immigration 101* and *Immigrant Youth Rights and Responsibilities Resource Guide*. *Immigration 101* was adapted from the "You Are Not Alone" handbook, which was developed for undocumented youth in the care of New York City Administration for Children's Services. *Immigration 101* introduced youth to common immigration terms and concepts, including their rights as immigrants, behavior/actions that could lead to deportation, and useful information after leaving DCFS care.

Trainers provided detailed instruction about involving immigrant youth in the completion of USCIS forms and ensuring youth understood the process of status adjustment. Staff was provided with *Immigration Resource & Practice Guide*, *Immigration 101*, and *Immigrant Youth Rights and Responsibilities Resource Guide*. The *Immigration Resource & Practice Guide* was adapted from New York City Administration for Children's Services' "Immigration and Language Guide for Child Welfare Staff" and the Santa Clara County's "Immigration and Naturalization Resource and Practice Guide." The *Immigration Resource & Practice Guide* provided staff with guidelines for working with immigrant families, descriptions of various immigration statuses, language issues, notification of foreign consulates, and detailed lists of DCFS, government and community resources.

The *Immigrant Youth Rights and Responsibilities Resource Guide (The Guide)* was a compilation of materials from the USCIS, the Illinois Coalition for Immigrant and Refugee Rights, and the National Immigration Law Center. *The Guide* was provided to all training participants as an added resource/reference.

The Inspector General's Office, with the assistance of the Guardianship Administrator's Office and the Director of Asian Affairs, is updating the aforementioned training materials and curricula in preparation for a statewide training in FY 08. The long-term goal is to offer immigration training to youth and staff on an annual basis.

ETHICS

Child Welfare Ethics Advisory Board

The Child Welfare Ethics Advisory Board was formed in March 1996 as an advisory body to the DCFS Inspector General. Its members are an interdisciplinary group appointed by the Inspector General.¹ The Child Welfare Ethics Advisory Board did not formally meet this year, but individual Board members provided consultation, as needed, to the Inspector General.

DCFS Ethics Officer

As Ethics Officer for DCFS under the Illinois Governmental Ethics Act, the Inspector General reviewed 673 Statements of Economic Interest that senior DCFS employees are required to file with the Secretary of State by May 1 of each year. Of the 673 statements submitted, 89 were further reviewed for potential conflicts. The Inspector General and the ethics staff noted entries that could constitute conflicts of interest. Potential conflicts were handled through educational efforts and through investigation, when appropriate.

Annual Ethics Training

As required by the State Officials and Employees Ethics Act of 2003, state officials and DCFS staff continued ethics training for all new, contractual, seasonal, and temporary employees. The Office of the Inspector General coordinates and monitors the ethics training for the Department. There were two training periods for which the OIG ethics staff notified employees registered to complete the training and monitored their completion status. Upon conclusion of each period, the OIG submitted a report to the Office of the Executive Inspector General for the Agencies of the Illinois Governor. The online ethics training for state employees consisted of lessons on various ethical dilemmas. In 2007, 3,133 DCFS employees completed the ethics training for a compliance rate of 97%. In addition to DCFS employees, DCFS board and commission members were asked to have their members complete off-line training. In FY 2007, a total of 150 individuals (100%) completed the off-line Ethics training.

¹ During this fiscal year, the members of the Child Welfare Ethics Advisory Board were:
Michael Bennett, Ph.D., Director, Egan Urban Center and Professor of Sociology, DePaul University
Jennifer Clark, Psy.D., Director, Child Protection Clinical, Cook County Juvenile Court Clinic
Michael Davis, Ph.D., Senior Fellow and Professor of Philosophy, Illinois Institute of Technology's Center for the Study of Ethics in the Professions
Armand Gonzales, M. D., pediatrician
James C. Jones, President and CEO, ChildServ
Jimmy Lago, M.S.W., M.B.A., Chancellor, Archdiocese of Chicago
David Ozar, Ph.D., Professor of Philosophy, Loyola University Chicago
David Schwartz, M.D., John H. Stroger Jr. Hospital of Cook County
Ada Skyles, Ph.D., J.D., Associate Director and Resource Fellow, Chapin Hall Center for Children, University of Chicago (Chair)

HOME AND FIRE SAFETY TRAINING

In FY 2007, Project Initiatives staff trained a total of 278 DCFS and private agency child welfare staff, and twenty-seven pregnant and parenting teen wards and their case managers on home safety.

To reduce the incidence of infant deaths resulting from co-sleeping, rollover, and infants being placed on inadequate sleeping surfaces, local field offices have continued the practice of providing child protection workers with portable cribs for DCFS involved families who do not have cribs for their infants. In FY 2007, an additional 100 cribs were distributed in Cook Regional field offices.

During FY 2007, the Inspector General's Office received a complaint that Central Region Child Protection Services Workers (CPSW) failed to complete the Home Safety Checklist for Child Protection Service Workers (CFS 2027). In order to determine whether the Home Safety Checklist was being completed as part of child protection investigations, the Inspector General's Office conducted a statewide sample of randomly selected investigations. Eighty percent of the cases reviewed had a completed Home Safety Checklist. However, the methods used by workers to fill out the checklist varied greatly, with the majority of workers not following checklist instructions. Also, the required Safety brochures were not routinely distributed, and supervisors were unfamiliar with how the literature reinforced the checklist safety standards.

As a result of these findings, it became apparent that the current Checklist format was confusing, cumbersome, and resulted in a myriad of interpretations. Project Initiatives staff incorporated these findings with feedback from the field to revise, streamline and standardize the checklists. Additionally, recognizing that investigators are under tight time constraints, Project Initiatives staff recommended that the safety literature and the checklist be bundled together to facilitate distribution and support workers in their efforts to keep children safe. The Project Initiatives staff also revised the Violence Prevention brochure.

CASE CONFERENCING FOR PARENTING TEEN WARDS

The Chicago School of Social Service Administration and Dr. Ron Rooney from the University of Minnesota School of Social Work continued work with supervisors and caseworkers from the Teen Parent Service Network (TPSN) on the use of a task-centered approach in supervision and direct work with pregnant and parenting teens. An accompanying series of videos was developed in consultation with Dr. Rooney using vignettes to enhance on-going case planning for the pregnant and parenting wards and their workers. These vignettes demonstrated situations caseworkers frequently encounter when working with teen parents, enlisting current caseworkers and young women who had successfully completed services to act out typical situations. The scenes depicted workers and mothers working to resolve conflicts with foster parents, progress toward reunification with their children, discuss concerns regarding boyfriends/fathers of their children and address other frequently arising issues. The videos will be used as training tools for caseworkers to model useful techniques in working with the teen parent population.

Deleted: (e.g. protective custody was taken); four percent were not completed because parents refused to sign the checklist; four percent of the investigative files contained no checklist. ¶

¶ A qualitative review of the completed forms revealed that the majority of workers did not complete the checklist according to the instructions. The inconsistencies prompted a revision to the checklist to simplify the completion of the form and provide a more standardized response from workers. Overall, the supervisors and workers who reviewed the modified checklist believed that the form was more user-friendly, less cumbersome, more streamlined and efficient, and less confusing than the previous design.¶

The OIG could not substantiate the allegations that Child Protection Service Workers were not completing the Home Safety Checklist. A closer review of the checklist, coupled with feedback from the field, resulted in a more streamlined and standardized revised checklist. A closer review of the literature disseminated with the checklist resulted in revising the violence Prevention brochure and bundling the revised checklist along with the literature. ¶

¶ -----Page Break-----

Reunification of Substance Affected Families¶

¶ The OIG Project Initiatives staff and the Department's Clinical Division developed recovery matrices with clear behavioral indicators. The matrices will assist caseworkers and the court with assessing the parent(s)'s progress in substance abuse recovery and parenting over time. The Substance Abuse Recovery matrices provide a consistent measure of observable change and progress over 12 month periods. The matrices also help parents by outlining progress in a holistic manner, focusing the parents and caseworkers on behaviors that are consistent with everyday parental responsibilities and progress in substance abuse treatment. The matrices provide consistent documentation across settings over time and support a common language among caseworkers, attorneys and the court. The following are the directions and form for the *Recovery Matrix For Placement Cases* (CFS 440-9): ¶

OLDER CAREGIVERS

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The Older Caregiver's Project, originally initiated as a pilot program in 2001, continues to provide training to a cross section of child welfare professionals through three different trainings: Kids and Older Caregivers, Older Caregivers Overview and Adoption Core. These trainings continue to focus on the needs of older caregivers and the challenges they face in caring for children.

Kids and Older Caregivers (KOCG)

This is a one-day training to educate staff, supervisors and managers about older caregiver families. Participants are provided tools to assess older caregiver families, and to promote long-term stability and permanency for children in these families. The Office of the Inspector General's Older Caregivers Project staff trained 137 Department and private agency staff statewide in FY 2007.

Older Caregivers Overview

Older Caregiver's Project staff developed a one-to-two hour presentation to educate professionals across service areas about the growing phenomenon of older caregiver families within the child welfare system. Participants are provided with data about the reasons for these placements, and efforts across state agencies to respond to the challenges faced by older caregiving families and service needs of these families. The training also provides the participants with a description of the projects in Illinois that assist older caregivers and the children in their homes. In FY 2007, project staff trained approximately 240 child welfare professionals statewide.

Adoption Core

Department staff has incorporated a four-hour training into the three-week DCFS Adoption Core Training, which the Project staff has presented. The segment provides a condensed version of the *Kids and Older Caregivers* training to Department and private agency adoption and placement workers and their supervisors. In FY 2007, 39 child welfare professionals participated in this training statewide.

Additionally, the Office of the Inspector General's Older Caregiver's Project staff continued training on and development of the *60+ Initiative*. The initiative, first introduced in Cook County in February 2006, was implemented statewide in FY 2007 and 35 Department employees have been separately trained on use of the 60+ checklist. Through this initiative, Adoption Liaisons meet with pre-adoptive parents age 60 and over to review back-up caregiving plans, should the caregiver become unable to parent. When concerns about back-up plans are raised, families can utilize mediation programs to resolve caregiving issues and conflicts.

SYSTEMIC RECOMMENDATIONS

Inspector General investigative reports contain both systemic and case specific recommendations. The systemic reform recommendations for Fiscal Year 2007 have been categorized below to allow for analysis of the recommendations according to the function that the recommendation is designed to strengthen within the child welfare system. The Office of the Inspector General is a small office in relation to the child welfare system. Rather than address problems in isolation, the Office of the Inspector General views its mandate as strengthening the ability of the Department and private agencies to perform their duties. Recommendation categories are as follows:

- ADMINISTRATIVE HEARINGS
- ADOPTION
- CHILD PROTECTION INVESTIGATIONS
- CONTRACTS
- COORDINATION BETWEEN DIVISIONS
- ETHICS
- LICENSING
- PERSONNEL PRACTICES
- SERVICES

ADMINISTRATIVE HEARINGS

The Department should develop a system to identify and track errors made in child protection investigations that were overturned on appeal. The system should inform individual child protection investigators, supervisors and managers of the errors. Management should then evaluate the need for enhanced training in light of the overturned investigation.

The Administrative Hearings Unit should develop and maintain a summary database that would be available to the field on administrative or judicial review of indicated findings.

The Department should develop objective guidelines for determining when an individual living in the home is a "person responsible for the child's welfare" for purposes of neglect.

ADOPTION

The Department should develop an internal mechanism to notify the post-adoption payment unit upon the death of a minor adopted child.

CHILD PROTECTION INVESTIGATIONS

The Department should ensure that child protection investigations, both unfounded and indicated, are not expunged while a subsequent investigation, involving the same family, is pending.

Department Procedure 300.70, "Referrals to the local law enforcement agency and State's Attorney," should be amended to include second-degree burns as injuries requiring referral to local law enforcement and the State's Attorney.

In child protection investigations involving an open DCFS case, the child protection investigator should arrange for an in-person joint interview of the caseworker and supervisor of the open case to obtain information pertinent to the child protection investigation.

The Regional Administrator of the appropriate region, or his designee, and the Chair of the appropriate Death Review Team should meet with the Executive Director of the appropriate county Mental Health (708) Board, to develop a system of timely retrieval of mental health records and efficient sharing of information, including interviews conducted by the mental health professionals, during a child protection investigation.

The Department should train Child Protection and Intact Family staff on utilization of the Social Security Administration's consent for release of information to obtain information on a parent or child's qualifying disability.

Child protection investigators, supervisors, and managers should be trained on the need to interview fathers during investigations, and on prompting questions used during supervision that will be required during investigations in which a physical injury is alleged.

The DCFS Medical Director should consult with local experts on child abuse to develop prompting questions for what, when, and how the information should be shared when seeking an opinion from a medical doctor about physical injuries. Procedure 300 should be updated to include this information.

Child protection investigators should be trained on sharing information with doctors during a child abuse investigation so that concerns about violating confidentiality will not put children at risk.

The DCFS Director should issue a clarification memo to the Division of Child Protection stating that involved fathers must be interviewed in child protection investigations.

The Inspector General's Office reiterates its prior recommendations that the Deputy Director of Child Protection should develop a list of prompting questions that must be used in supervision of all investigations in which a physical injury is alleged. Use of this list should be required by Procedures 300 and included in the investigative record. Questions should include, but not be limited to:

- Have there been a series of injuries to child(ren) in the home in the last 6 months?
- Have there been any changes in household composition or caretaking that correspond with the onset of injury?
- If parents are separated or divorced, have both parents been contacted for information and/or placement?
- Has there been a delay in seeking care for any of the injuries?
- Were there any witnesses to the injury; if so, what did the witnesses report?
- Is the explanation for the injury consistent with the injury? Whose opinion is it and what facts were shared?
- Were conflicting explanations given for the injury? What were they and by whom?
- Are the injuries occurring only in one setting (e.g., home, school or daycare)?
- Are the injuries occurring only with one particular caretaker?
- Have the factors allegedly causing the injuries occurred across settings?
- Was there corroboration for the explanations given for the injuries? What was it?

Rule 431 should be amended to clarify that DCFS can share unfounded investigative information during a subsequent child protection or criminal investigation with any persons named in Section 11.1 for purposes consistent with the Abused and Neglected Child Reporting Act (ANCRA) or criminal prosecution.

DCFS Legal should issue a clarification memo to Legal staff stating that unfounded reports can be shared with coroners, medical examiners, and State's Attorney's when relevant to a pending criminal or child abuse investigation.

Department Procedures should be amended to include a provision that when someone walks into a DCFS office with a concern about child abuse or neglect, they should be invited into the office to make a hotline report or to talk to an investigative supervisor if they have questions or concerns about making the report.

Department Procedures should be amended to require that in child protection investigations in which the plan is for a family member to obtain private guardianship of the child(ren), the family should be referred to the Extended Family Support Program for assistance in obtaining private guardianship.

The Department should reformat the Home Safety Checklist for Child Protection Service Workers (CFS 2027) and the Home Safety Checklist for Intact and Permanency Workers (CFS 2025) to make them more user-friendly.

Because current Procedure 300, Section 300.60 c) which states "non-custodial parents need not be interviewed unless believed to have information regarding the injury or situation" does not convey the importance of non-custodial parents as sources of information, the OIG recommends that this section of Procedure 300 be amended to state that *there is a presumption that involved non-custodial parents have relevant information and therefore should be interviewed during the child protection investigation.*

CERAP

The new Child Endangerment Risk Assessment Protocol (CERAP) should eliminate the use of Safety Thresholds and limit the Safety Information Standards to those necessary to good investigative practices.

The focus of CERAP training should be on conducting a solid investigation of the allegations.

CONTRACTS

The new Contract Monitoring Protocol should include toxicology contracts. Toxicology contract monitoring should include a specific provision requiring review of Approval Forms and incorporation of guidelines developed by Service Interventions.

The Department should develop an electronic system for tracking and linking resource approvals, caseworker sign-offs on service delivery and billings reviews.

Drug and alcohol toxicology contracts should be competitively bid.

COORDINATION BETWEEN DIVISIONS

The Department should develop guidelines for shared monitoring responsibilities when a single foster home has children monitored by different agencies or when the case monitoring and license monitoring functions are split between agencies. The guidelines should include the following requirements: a) a staffing of all involved case and licensing workers; b) written agreement of roles and responsibilities of each worker; and c) written guidelines concerning the responsibility to share information and the process for sharing information.

The Department should issue a policy memorandum stating that whenever possible, each foster home should have a single entity that monitors placement of foster children and foster home licensing. POS may grant waivers to the policy based on individual children's needs but must ensure that the guidelines stated above are in place whenever a waiver is granted.

Whenever a waiver is not granted, and case responsibility is transferred to a single agency, the relinquishing agency should not be penalized, but should be moved up for case rotation assignment of a new case.

The Department should ensure that licensing and casework information on SACWIS is available to all licensing workers, caseworkers and their supervisors assigned to a foster home.

ETHICS

When a child welfare worker believes he/she has an irresolvable personal conflict to service a pregnant minor because of personal values or biases, the worker should be required to immediately notify his/her supervisor to avoid harm to the client. The worker should follow up notification to the supervisor with a written request for recusal from the case.

The Department should expand the Conflict of Interest Committee to include representatives from Clinical, Field Operations and Service Intervention. A representative from each division should be chosen by their respective Deputy Directors to serve on the committee.

Department supervisors should review secondary employment at the time of the annual review to see if a conflict has developed that was not present when the employee accepted employment.

A task group should be assembled to revise Rule 437 and draft relevant procedures. The task group should consider the extent to which Purchase of Service agencies should be included in Rule 437.

LEGAL

The Department's Division of Legal Services should draft a standardized form for the appointment of short-term guardianship and provide training on proper use of the form.

LEGISLATIVE

The Department's legislative liaison should pursue legislative amendment to Illinois Statute 430 ILCS 65/4-65/10 Public Safety to address the need to revoke firearm registration of parents who demonstrate an inability to keep their firearms from minors under a set of conditions that include: minors, age 16 and under, with a mental condition or behavior that poses clear and present danger to self or other persons (e.g., discharging firearms in the absence of parental supervision, shooting guns at other persons, taking weapons or ammunition to school).

LICENSING

The Department should evaluate and address private agencies' practice of sharing homes (this occurs when one agency oversees the licensing of the foster home and another the placement of children in the home) between agencies for licensing and child welfare placements.

Department Procedure 383, Licensing Enforcement, must be revised to address the deficiencies in notification and completion of licensing investigations of licensed foster homes.

Until a new Procedure is developed, the Department must immediately implement a protocol to ensure needed notification of Licensing and Child Protection investigations to all licensing and child service workers.

Department licensing standards should require a reassessment of a foster home license when the licensing agency becomes aware of a major change in the family composition, such as a spouse/paramour moving out of the home. The reassessment should include a review of the foster parent's capability to care for the children in light of the loss of a second caretaker, as well as the circumstances surrounding the change and any ensuing custody or other legal disputes.

MEDICAL

The HealthWorks contract should be amended to ensure that:

(A) At the Initial Health Screening, if a pregnancy is confirmed, an obstetrical ultrasound is performed to confirm that the pregnancy is in the uterus and to estimate the gestational age of the fetus, and that a health professional advise and counsel the youth regarding pregnancy options.

(B) For pregnant minors and children with serious or chronic illnesses, either expand the Initial Health Screening to include a Comprehensive Health Evaluation OR complete a Comprehensive Health Evaluation within 7 days from the Initial Health Screening.

PERSONNEL PRACTICES

The Department should ensure that the Office of Child Welfare Employee Licensing has an established practice of academic credential verification of individuals, and verification of accreditation status of unfamiliar post-secondary schools.

Access to timekeeping records should be limited to timekeeping personnel and should be maintained in a locked file cabinet.

The Department should send a clearly stated directive to all employees directing them to cease using e-mail for other than state or Department business and that the Department will not tolerate improper use of e-mail with State equipment and on State time. The directive should state that e-mailing jokes, poems and inspirational messages are inappropriate and should never be forwarded. Employees should be advised to inform the senders that such e-mail should not be sent. The Department should advise employees that e-mail from agencies that include solicitation for funds should not be forwarded. Employees should be reminded that misuse of the e-mail system will result in discipline, and the Department must follow through on administering employee discipline when inappropriate e-mails are found.

The License Administrator from the Office of Child Welfare Employee Licensure should provide training to staff from the Office of Employee Services on the grounds for licensure action and the method for referrals.

STATE CENTRAL REGISTER

The State Central Register (SCR) Call Floor Manual should be reviewed for accuracy and cultural sensitivity, and revised to conform to the SCR policy.

The State Central Register staff should participate in remedial training related to non-English speaking callers.

SERVICES

Adoption

The Department should require Administrative Case Reviewers to consult the Control Group List whenever Subsidized Guardianship is a potential permanency option for a child to determine eligibility.

The Director of the Department should send a letter to each of the county clerks (excluding Cook County) requesting that a clerk check for other court involvement (e.g. open juvenile court case) prior to a proceeding for guardianship of a minor.

Birth Certificates

The Department should issue a memorandum to DCFS employees and private agencies that workers should not have foster parents or other individuals procure a Vital Record when one is needed.

Department workers and private agency employees should be using the DCFS Form for such request, but only after an attempt has been made through the county clerk for the record.

The DCFS form for Birth Certificate Requests should be revised to include the requestor's name, title, signature, and contact telephone number and the date of the request. A section for the Purpose of the Request should be included and if used for court, a space for the Docket Number of the case should also be included.

Intact Procedures should be revised to show that Certified Copies of vital records will be assessed a fee and that the fee on Administrative Copies of vital records will be waived by the Department of Public Health, but not necessarily by the local county clerk. This procedure should also address the issue of prepaid postage.

Clinical

The Department's Guardianship Administrator should identify and review all wards who have a current diagnosis of Reactive Attachment Disorder (RAD), and develop and implement a plan to determine whether these children and youth were properly diagnosed and are receiving appropriate treatment or whether they require an evaluation that follows recommended guidelines of the American Academy of Child and Adolescent Psychiatry, and the American Professional Society on the Abuse of Children. The OIG will provide the Guardianship Administrator with the two investigations where RAD was misused.

The Procedures for Child and Youth Investment Team should be amended to include situations in which a placement move is requested for any reason other than a ward's best interest.

Developmentally Delays

The Department should develop a protocol for advising clients with developmental delays of their rights.

The Department should develop a specialized Intact Family team with experience and expertise in working with developmentally disabled parents. In the alternative, the Department should provide Intact Family workers with training on working with parents with developmental delays.

The Department's Division of Clinical Practice should develop training and resources for working with caregivers with developmental disabilities to be included in the Department's core training curriculum.

The Department should amend Procedures 302.388 Intact Family Services to provide that parents with developmental disabilities are referred to community resources that specialize in working with the developmentally delayed population for community linkages and additional case management services.

The Department's Division of Clinical Practice should assist child protection and case management staff in managing cases involving caregivers who have a developmental disability.

Fathers

The Department must monitor and enforce contract compliance of private agencies to acknowledge and include fathers and paternal family members as an integral part of case management services. DCFS monitors must ensure that DCFS Procedures: Services Delivered by the Department and its Appendix J: Pregnant and/or Parenting Program are followed.

General

When a child welfare worker has a pregnant mother on his/her caseload who has been previously indicated for abuse or neglect, and refuses to give the child welfare worker information as to the due date and expected place of delivery, and the worker has concerns about the new baby, the worker should

increase visitation within 2 months around the anticipated due date, document attempts to get consent to speak with doctors, and document contacts with family and support network to seek notification of birth.

If the pediatric nursing facility is located more than a hundred miles from the case manager's home office, and no other case management issues necessitate assignment of a case manager at such a distance, the Department should transfer the case management to an office near the facility.

Immigration Services

The Deputy Director of the Division of Service Intervention should issue a communication to all DCFS regional educational advisors instructing them of their obligation to provide educational advocacy for foreign-born wards.

The Department should authorize the Immigration Services Unit Coordinator to have "read-only" access to view SACWIS. Access to SACWIS would provide the Unit with current information about a child's living arrangements, court status, service plan, caseworker, and the integrated assessment.

The Department should ensure the Immigration Services Coordinator has all available resources to enable her to provide direct guidance to wards and workers.

The Department should revise Procedure 327, Guardianship Services, Appendix F – Immigration/Legalization Services for Children with Undocumented Status to reflect current practices. Because of the complexity and unfamiliar nature of immigration services to child welfare staff, the Department should develop a resource link on the D-Net to provide workers with a central location for obtaining needed information/instruction. There should be communication within the Department regarding the development of computerized/satellite training to reflect current practices of the Immigration Services Unit.

The Immigration Services Unit's referral form should be revised to include information about the child's employment history and current employment needs and be approved as an official Department form.

Given that timely identification of undocumented wards who may be eligible for Special J status with the United States Citizenship and Immigration Services (USCIS) is necessary to ensure future service delivery and continued best interest: a) The Immigration Services Unit should re-implement the tracking process/database for all referrals received; and b) Questions regarding a child's citizenship status should be added to the Client Service Plan (hard copy and SACWIS).

Given that obtaining a child's birth certificate through a foreign consulate/embassy is an unfamiliar process to most caseworkers, the Immigration Services Unit should expand its duties to assist caseworkers with this task regardless of the child's permanency goal. Immigration Services Unit personnel have special knowledge of working with foreign consulates/embassies. Should the child's permanency goal change from Return Home, the caseworker would have the necessary documentation to facilitate a Special Immigrant Juvenile Status (SIJS) petition.

The Department should consider developing a Street Law educational model for undocumented and foreign-born wards in need of immigration services.

A majority of children receiving assistance from the Immigration Services Unit originate from Spanish-speaking countries. The Inspector General recommends referral coordination between the Burgos Unit and Immigration Services Unit.

Intact Family

DCFS should amend Intact Family Services Procedures to provide that children and parents with epilepsy are referred to the Epilepsy Foundation for education, case management and assistive resources.

DCFS should amend Intact Family Services Procedures to provide that when a parent has a condition that may become debilitating, intact family staff should ensure that the parent has a back-up caregiver plan that meets the child's medical, developmental and scholastic needs.

To best meet the clinical needs of children and families, Intact Family Procedures should require a case conference be convened as part of the clinical provider's family assessment process to discuss treatment needs identified in the DCFS Integrated Assessment. The case conference should include all service providers involved with the family and involved extended family members.

Older Caregivers

A representative from the Department's Division of Training should regularly update older caregiver training content to promote consistency and incorporate new material into regular training curricula.

When officers of the court receive older caregiver training, DCFS Legal should be present to ensure consistent information and coordinated service delivery.

DCFS Training should develop guidelines to ensure that all information given to older caregivers, including information related to financial and health care planning, is consistent with material from the Bureau of Elder Rights and the National Adult Protective Services Association.

When a biological parent is identified as an appropriate long-term option as caregiver of the child and the family desires to implement that option, DCFS Legal should be involved, the case should be brought to court, the subsidy should end, and the Department should offer services to ensure the safe and successful permanency of the child's return home. These cases should be incorporated into the Department's statistical count regarding reunification efforts.

The Subsidized Guardianship Agreement should be amended. At a minimum this agreement should allow for payment suspension and termination of the agreement when custody of a minor is restored to a biological parent. In the interest of complete and full disclosure however, the possibility of a child returning to his/her biological parent and the steps necessary for that to occur should be clearly identified in the General Provisions Section of the Agreement.

In any case in which a change in guardianship essentially represents a return home, DCFS Legal should be involved to ensure that the appropriate petition is filed in the appropriate court and to represent the Department at any subsequent hearing on the matter.

The Department should immediately implement practice changes suggested by an older caregivers Pilot Program including: a) expand post adoption services to provide additional assistance to families in which an adoptive parent or legal guardian dies; b) develop written information about how to implement an identified back-up plan; and c) develop resources to complete home studies and interim studies for children in subsidized guardianship, or adoption to subsidized guardianship conversion situations.

The Department should consider approving the Grandparents and other Relatives Raising Children brochure for child welfare staff.

Substance Abuse

The anticipated training on graduated sanctions for child welfare workers should include more detailed court training, including: how to testify; how to screen; overlapping court involvement; and orders of protection.

The Department should have a written policy, developed by the Service Intervention Division, dictating the requirements for drug and alcohol drops. The policy and subsequent training should specify red flags that the Contract Liaison should look for in reviewing the Billing Summaries.

Pregnant and parenting teens

The Teen Parenting Service Network's phone line should be used during regular business hours (Monday through Friday, 9 am to 5 pm) for child welfare workers to report a teen pregnancy as soon as it becomes known.

Within 48 hours of receiving notification of a minor's pregnancy, the Teen Parenting Service Network should follow up with the assigned private agency to ensure pregnancy options counseling is provided and timely scheduling of medical follow-up for prenatal care is made.

The Department's Unusual Incident Reporting Form (UIR) – Type of Incident Checklist – section should be changed as follows to more clearly communicate the minor's status (pregnant, parent, or both):

- L02 (a) Identification of parenting ward
- L02 (b) Discovery of a ward's pregnancy

The form should also require notification of TPSN intake.

RECOMMENDATIONS FOR DISCIPLINE AND CONTRACT TERMINATION

The Inspector General's Office recommended discipline of Department and private agency employees for the conduct detailed below. Discipline recommendations ranged from counseling to discharge.

- During an investigation of cuts, welts, and bruises to a two-year-old, a Child Protection Specialist, when requesting an opinion from the treating physician, failed to inform the physician of a second hotline report by a mandated reporter and additional injuries to the child that had occurred since the paramour moved into the home. That additional information would have provided the physician with information pertinent to classifying injuries as abuse.
- A Child Protection investigator had lunch and secured secondary employment with a parent she had previously investigated, and failed to inform her supervisor of the lunch or her secondary employment and the potential for conflicts of interest.
- A Contractual Employee violated the Illinois state law requiring compulsory education of Illinois children to the age of 17 (105 ILCS 5/261) and demonstrated a bias by enrolling a 16 year-old Latina ward in an adult literacy/parenting program rather than ensuring that the ward was integrated into a high school setting.
- An Intact Family Case Manager defrauded the Department and worked a second job during state time, which prevented him from completing home visits and case documentation.
- An Intact Family Supervisor failed to provide adequate supervision to an Intact Family Case Manager who failed to complete home visits, case documentation and accountability for hours worked away from the office.
- A Child Protection Specialist failed to interview the cousin or cousin's caretaker in an investigation of cuts, welts, bruises in order to corroborate the explanation given for the injuries to a 10-year-old child; failed to interview the 10-year-old child victim in a subsequent investigation of cuts, welts, bruises; failed to consider evidence from a previous indicated investigation for cuts, welts, bruises against the ten-year-old's adoptive aunt in a subsequent investigation of cuts, welts, bruises against the adoptive mother; failed to provide the treating physician with the context of the injury in an investigation of cuts, welts, bruises while asking for the physician's opinion; failed to recognize that cumulative injuries required further investigation into the supervision of a 10-year-old child or monitoring through a referral for services; failed to recognize that the adoptive mother's unwillingness to fully cooperate in the investigation of cuts, welts, bruises compromised the Department's ability to monitor the child's safety.
- After three investigations of cuts, welts, bruises to a ten-year-old child, a Public Service Administrator requested the fourth investigation be transferred to another team for investigation. However, the Administrator failed to provide the assigned Child Protection Specialist with a printout of a related investigation of cuts, welts, and bruises. Her failure to consider that the adoptive mother's lack of cooperation and her previous authorization for physical punishment to the substitute

caregiver compromised the Department's ability to monitor the child during the pending investigation.

- A Child Protection Specialist, during an investigation for allegations of cuts, welts, bruises to a 10-year-old child failed to verify the adoptive mother's claim that the injuries could have occurred at school; failed to complete a data check, which would have revealed a previous CANTS history on the family; failed to explore who provided care for the child after learning of the adoptive mother's work schedule; failed to interview the adoptive mother's paramour; and failed to interview extended family who had knowledge of the child's injuries.
- A Child Protection Specialist failed to critically investigate whether serious burns to a two-year-old child were accidental. During the investigation, the Child Protection Specialist's caseload was above B.H. limits.
- A Child Protection Supervisor failed to ensure an investigator critically analyzed whether serious burns to a two-year-old child were accidental.
- During an investigation against a mother for substantial risk of harm to her infant, a Child Protection Specialist did not consider the significance of either a previously indicated report for substantial risk to a one-year-old now in DCFS custody or that the grandmother had obtained an Order of Protection against the biological mother; accepted the direct report of the parent being investigated without checking facts; failed to corroborate information with key mental health collaterals and failed to obtain relevant mental health documents.
- During an investigation of wounds by neglect and substantial risk of physical injury by neglect to a 14-year-old child, a Child Protection Advanced Specialist failed to review the prior CANTS history on a family and interview the family's previous intact case manager in accordance with Procedures 300. At the time of the investigation his caseload was above B.H. limits.
- A Child Protection Supervisor failed to instruct a Child Protection Advanced Specialist to review the prior CANTS history on a family and interview the family's previous intact case manager as required in accordance with Procedures 300 during the investigation of wounds by neglect and substantial risk of physical injury by neglect of a 14-year-old child. At the time of the investigation, the supervisor's team's caseloads were above B.H. limits.
- A Child Protection Manager did not ensure that an investigation of reported allegations of wounds by neglect and substantial risk of physical injury by neglect to a 14-year-old child was completed prior to approving the final finding of the investigation. The volume of investigations at this time in the geographical region was above B.H. limits.
- A private agency Case Manager failed to inform the court that a 17-year-old undocumented ward returned home to live with her biological mother. Also, the case manger requested that the ward sign a legal document without providing an explanation of the form or the legal proceedings.
- A private agency Supervisor did not ensure that a new Case Manager, handling a case with complex immigration issues, understood the complexities of the case and protected the child's rights.

- An Administrator failed to discharge her duties in ensuring appropriate services to a Spanish-speaking client and failed to recognize a conflict of interest with the Supervisor servicing the intact family case.
- A Supervisor violated a client's rights by having a Spanish-speaking biological mother with developmental disabilities sign a legal document, written in English, which gave custody of her child to a third party.
- A Child Welfare Advanced Specialist falsely documented visits to a quadriplegic, mentally retarded, medically complex ward living in a long-term care facility. The case manager falsified records in claiming travel expenses for trips that she did not make.
- A Public Service Administrator falsified her time records and attempted to alter the records following an interview with the OIG. The Public Service Administrator also failed to cooperate with an OIG investigation by refusing to provide information.
- A Senior Public Service Administrator signed off on falsified time records.
- A private agency Case Manager responded insensitively to a foster child's enuresis trying to stop the behavior by embarrassing the child.
- A private agency Supervisor failed to address the Case Manager's insensitive questioning of a foster child who suffered from enuresis.
- A private agency Therapist failed to assess the safety of a six-year-old child in the home of his mother, and failed to assess the child's behavior in school, and the parent-child relationship. She also failed to address the recommendations made in the family's Integrated Assessment and did not include the child in the treatment plan.
- A private agency Clinical Services Supervisor did not ensure safety of a six-year-old child in the home of his mother or ensure that the assigned therapist's assessment and subsequent treatment plan addressed the issues highlighted in the family's Integrated Assessment.
- A private agency Intact Family Case Manager failed to monitor a nine-year-old diabetic's medical needs.
- During an investigation of medical neglect of an eight-year-old child, a Child Protection Specialist failed to complete a data check, review a prior indicated child protection investigation of medical neglect, and obtain relevant medical records.
- A Child Protection Specialist failed to respond to a diabetic child's immediate health crisis, obtain relevant medical records and review prior child protection investigations as required by Procedures 300: Appendix B. The Child Protection Specialist also demonstrated a lack of diligence in locating the family.
- A private agency Administrator failed to assure a ward's case moved toward permanency in a timely manner.

- A Child Protection Specialist failed to assess risk or the mechanisms for injury during two separate investigations of allegations of bruising to an infant. The Child Protection Specialist also failed to address a household member's previous violent behavior and failed to assess the mother's ability to parent in light of severe developmental disabilities.
- A Child Protection Supervisor failed to ensure a Child Protection Specialist assessed risk to an infant during an investigation of allegations of bruising, approved CERAPs (Child Endangerment Risk Assessment Protocols) that did not address a household member's previous violent behavior, and failed to assess the mother's ability to parent in light of severe developmental disabilities.
- A private agency Intact Family Case Manager did not adequately assess a family for intact services, minimized signs of violence, intimidation, a threat to kill the baby and possible exploitation in the home, and provided false information to the OIG.
- A private agency Intact Family Supervisor failed to recognize a relative's paramour as a member of the household, failed to ensure a realistic service plan was developed, and failed to recognize signs of domestic violence in the home.
- A Contract Monitor accepted gifts from the vendor of a contract he monitored without notifying his supervisor and without documenting donation of the gifts to charity. Further, he failed to adequately monitor the contract and determine that the billings were accurate.
- During the course of a child protection investigation, a Child Protection Specialist used the influence of his professional position to advance a personal relationship with a woman he was investigating for allegations of substantial risk of injury/environment injurious.
- A Child Welfare Specialist violated Confidentiality Rule 431 by accessing SACWIS (the State Automated Child Welfare Information System) and providing abuse and neglect information to a member of her community.
- An Intact Family Supervisor defrauded the Department and worked a second job during the same time as her state employment.
- A Child Protection Supervisor misused her authority and State position in an attempt to receive preferential treatment after being stopped for a traffic violation, falsely claiming that her traffic violation was necessary because of her work on a death case and suggesting that the relationship between the police and the Department would be adversely affected if she received a ticket.
- A long-term Employee was found to have a conviction that makes it unlawful to be employed by the Department.
- An Employee submitted vouchers that contained false information and were issued to purchasers that had no relationship with DCFS. The issued vouchers benefited family and friends of the employee.

- A Child Protection Advanced Specialist failed to make a referral for a DASA/DCFS Initiative Assessment as required by Procedure 302 Appendix A-Substance Affected Family for a mother who gave birth to a substance exposed infant.
- A Child Protection Supervisor failed to critically review a Child Protection Service Worker's Substance Abuse Screen and ensure a mother who gave birth to a substance-exposed infant was referred to DASA/DCFS Initiative Assessment as required by Procedure 302 Appendix A-Substance Affected Family.

The Inspector General's Office recommended the termination of Department contracts for the conduct detailed below.

- A Vendor submitted fraudulent billing to the Department for services not rendered.

LAW ENFORCEMENT CASES

In FY 2007, the Inspector General referred seven cases to law enforcement agencies and local State's Attorneys and received three requests for assistance from law enforcement agencies. In addition, indictments were issued in two cases referred to law enforcement in FY 2006.

Case 1

The Department referred an investigation to the State's Attorney for prosecution of a DCFS contractor that had over billed the Department by approximately \$2.5 million for drug tests that had never occurred. The contractor has been charged with two counts of Class X Theft Felonies; Felony Financial Crimes and Money Laundering as well as Fraud and False Statements. The criminal case is pending.

Case 2

The Office of the Inspector General received a complaint of fraudulent use of vouchers by a DCFS employee. The OIG substantiated fraudulent use of vouchers and the matter was referred to the Illinois State Police for criminal investigation. The investigation is ongoing.

Case 3

The Office of the Inspector General referred an employee to the Illinois State Police for criminal investigation after learning that the employee maintained two jobs with overlapping hours. The State Police declined to investigate further.

Case 4

A former ward died at 11 years of age. The Medical Examiner's office ruled the death a homicide. No one was charged in the case. Prior to the death, there had been several child protection investigations involving allegations of abuse to the minor by family members. After completing a death investigation, the Inspector General referred the case to the State's Attorney's Office for re-examination of the death as a homicide and to recover the subsidy the adoptive mother continued to receive for almost a year after the death.

Case 5

A DCFS employee alleged that she received a threatening letter. The matter was forwarded to the State Police for investigation. The State Police declined to investigate further.

Case 6

The United States Department of Housing and Urban Development (HUD) investigations unit contacted the OIG regarding a woman who they believed to be the biological mother of a minor for whom the woman was receiving an adoption subsidy. The OIG investigation revealed that the minor involved had been adopted by his aunt, who was the person receiving the subsidy. HUD was given the information necessary for verification.

Case 7

The Inspector General of Social Security Administration contacted the Inspector General's Office about a former Department employee who was applying for disability benefits. SSA needed information about the former employee's leaves of absence and worker's compensation claims. The information was obtained and forwarded to the Inspector General for the SSA.

Case 8

The State's Attorney's Office contacted the OIG to confirm that a case of sexual abuse of a teen, whose mother was involved in a case with the State's Attorney's Office, was being investigated by DCFS.

Case 9

The Office of the Inspector General referred a father, whose children had been removed years previously, to the Illinois State Police for investigation of threats made to public officials. The father's picture was distributed to several DCFS offices.

Case 10

The Department referred an investigation to the Illinois State Police regarding a DCFS supervisor who had allegedly attempted to use her official position with the Department to avoid receiving a traffic ticket. The Illinois State Police declined prosecution.

UPDATES FROM FY 2006**Case 11**

In FY 06, the Office of the Inspector General referred a case of the transfer of funds from a POS agency to a private account to the State's Attorney's Office. The party involved was indicted in May 2006. As of December 2007, the criminal case is still pending.

Case 12

A case was referred in FY 06 to the Illinois State Police for credit card fraud and forgery. Two people were indicted. One of them pled guilty in June 2007 to forgery and was sentenced to 3 years 6 months in prison. The companion's case is still pending.

DEPARTMENT UPDATE ON PRIOR RECOMMENDATIONS

The following OIG recommendations were made in previous Fiscal Years, but were not fully implemented before the Annual Report was issued. Their current implementation status is detailed below in the following categories.

- Child Protection
- Contract Monitoring
- Foster Home Licensing
- General
- Medical
- Personnel
- Private Agency Monitoring
- Statewide Automated Child Welfare Information System
- Substance Abuse
- Teen Parent Service Network

CHILD PROTECTION

Rules and Procedures should be amended to provide that new injuries can raise suspicion regarding old injuries, previously believed accidental, and that when this occurs, investigators need to share new information and work collaboratively with all available professional resources, such as hospital child abuse teams or Child Advocacy Centers (from OIG FY 04 Annual, Death and Serious Injury Investigation 3).

FY 04 Department Response: A workgroup to revise Procedures 300 was convened and will address this issue with DCFS Legal for possible liability regarding discussing previously unfounded reports with available professional resources and appropriately documenting a review and consideration of previously unfounded reports in a current investigation. Completion Date: February 2005.

FY 05 Department Update: These items were referred to the Legal Division for an opinion regarding possible legal ramifications. Legal is still assessing these matters.

FY 06 Department Update: The Division of Child Protection Committee has not completed their review and final revisions to Procedures 300. Once completed, the procedures will be returned to the Office of Child and Family Policy to begin the process of approval from JCAR. Implementation date: Spring 2007.

FY 07 Department Update: The Office of Child/Family Policy has forwarded the final draft of Procedures 300 to the Division of Child Protection. The Procedures 300 workgroup is reviewing the final draft and expects completion by December 2007.

The Regional Administrators for this region should develop an effective communication system with local hospitals to assist investigators with contacting key medical informants in abuse and neglect investigations. In hospitals with child protection teams, the chair of the team can assist in developing a timely response. In hospitals without a child protection team, DCFS management should reach out to hospital administrators to have a designated contact to assist the investigator in contacting a mandated reporter and other key hospital informants. If requested by the hospital, DCFS should assist in the formation of ad hoc child protection teams that can be convened on an as need basis (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 2).

FY 05 Department Update: The Cook County portion of this recommendation is complete. Many Downstate hospitals do not have child protection teams and this combined with the number of possible hospital participants has caused delay. Also, with the planned statewide re-alignment/re-organization of worker and management staff, it appears best not to assign Department staff until after this has occurred to avoid possible reassignments. This task is targeted for completion by the second quarter of 2006.

FY 06 Department Update: Meetings continue with the three community based hospitals to work out standardized medical procedures and referrals. The group is continuing efforts to develop and finalize a 24-hour coordinated response by DCFS, law enforcement, Child Advocacy Center staff and state's attorneys. Downstate Regional Administrators will compile a list of local hospitals and facilitate the designation of various Investigation Supervisors to serve as liaisons to local hospitals in their areas. Target date for completion of this task: December 2007.

FY 07 Department Update: The regions planning committee to specifically initiate start-up of a Medical Resource Center and Hospital Coordination project began in June 2007. DCFS has committed \$100,000 from the Children's Justice Grant to establish an expert consultation team for medical evaluation and treatment of abused children for the area. A contract is to be submitted on November 5, 2007, with comprehensive services to be implemented beginning January 1, 2008. The planning group is preparing a presentation for outreach to the medical, social service, child protection, and law enforcement communities during December 2007 and the first quarter of 2008.

Administrative Procedure 6 should be amended to conform with Rule and Procedure 431, requiring workers to access underlying documents for the purpose of sharing relevant criminal history with outside service providers (from OIG FY 05 Annual Report, General Investigation 34). The practice of disseminating the actual LEADS printouts should stop. LEADS Operators should provide a verbal or written assessment of the LEADS printout, as provided in AP6 (from OIG FY 05 Annual Report, General Investigation 34).

FY 07 Department Update: The committee approved a draft of Administrative Procedure 6 that addresses the OIG recommendations and has been approved by the Illinois State Police.

The Department should amend procedures and the CERAP to require that LEADS checks be used to inform CERAP decision-making (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 7).

FY 05 Department Response: The CERAP Committee is reviewing this report to use in drafting revisions to CERAP.

FY 06 Department Update: The Safety Workgroup continues to review the CERAP project. Target completion date: Spring 2007. Domestic Violence Procedures and Practice Guide, Policy Transmittal 2005.07, and registration for training, which is being offered through June 2006 was posted on the D-Net in September 2005.

FY 07 Department Update: The draft being field-tested includes this requirement.

Child Protection Management should ensure that Quality Assurance is capturing necessary data to permit easy assessment of staffing needs. Specifically, current caseload assignment information should differentiate between full investigations and mandates (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 6).

FY 07 Department Update: This option has been implemented.

The State Central Register should revise the Notice of Indicated Finding sent to parents to comply with Rule 336.60 (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 6).

FY 05 Department Response: This recommendation is under review by the DCFS Legal Division because of the impact it may have on the DuPuy Federal lawsuit.

FY 06 Department Update: Revisions are on hold pending implementation of the changes required by the DuPuy Federal lawsuit. Changes will be implemented as soon as possible, but no later than July 17, 2007.

FY 07 Department Update: Revisions were placed on hold by DCFS Legal due to changes required by DuPuy Federal Lawsuit. As of November 2007, litigation is ongoing and it appears additional changes to the notice form may be required. DCFS Legal will continue to monitor and will draft an updated form when legal issues have been resolved. The anticipated implementation date is May 2008.

Provide training and written guidelines for mitigation and development of safety plans, including specific components that should be in place for specific safety concerns, such as violence and physical abuse. The training and guidelines should address the need to consider inclusion of extended family or protective daycare as partners in implementing the safety plan (from OIG FY 06 Annual Report, General Investigations 16).

FY 07 Department Update: The draft CERAP, currently being field tested, does not provide guidelines for mitigation and development of safety plans specifically addressing safety plans with violence or physical abuse issues.

Once a risk is identified, workers need more guidance on how to determine whether the risk is “urgent” or “immediate” (from OIG FY 06 Annual Report, General Investigations 16).

FY 07 Department Update: The draft CERAP, currently being field tested does not provide guidelines on how to determine if risk is “urgent” or “immediate.”

Add a third box to each safety factor, acknowledging that information for that factor may be “unknown” or “uncertain” and add a section at the conclusion of the factors list for identifying information that needs to be gathered in the future to further assess safety (from OIG FY 06 Annual Report, General Investigations 16).

FY 07 Department Update: The current draft CERAP that is being field-tested provides two assessment tools. The first is used at the outset and permits workers to note that more information is needed before the question can be answered.

Devise a supervisory form to accompany the safety assessment that would allow a supervisor to determine the source of information that formed the basis of the particular safety factor decision and provide a check that basic available objective sources (such as the hotline report, prior child protection investigations, police reports and interviews with police, and criminal history information as required by Administrative Procedure 6) (from OIG FY 06 Annual Report, General Investigations 16).

FY 07 Department Update: The draft CERAP, currently being field-tested does not provide prompts or checks for determining source of information.

The Department should ensure that available fathers be explored as potential placements. If a safety plan is likely to last longer than six months, the Department should facilitate a legal relationship between the child and the caretaker (from OIG FY 06 Annual Report, General Investigations 11).

FY 06 Department Response: A committee has been formed to revise the safety assessment process. The Committee continues to work on the safety assessment framework protocol. Targeted completion date is June 2007.

FY 07 Department Update: The CERAP draft, currently being field tested, directs the attention of the worker to consider available fathers as potential placements.

The Department should ensure that subpoena training and training on accessing confidential medical and other information is included in CORE child protection training. Until such training can be implemented, and for current child protection staff, Department regional attorneys should conduct trainings throughout the state to ensure an understanding of the Department’s ability to access such information, as well as the mechanics of issuing subpoenas (from OIG FY 06 Annual Report, Death and Serious Injury 11).

FY 06 Department Response: The Division of Child Protection worked with the Legal Division to revise and update the administrative subpoena (CANTS 7), which is on DCFS templates available for all staff.

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

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

FY 07 Department Update: DCP worked with Legal Division to revise and update the administrative subpoena (CANTS 7), which is on DCFS templates available for all staff.

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

Additionally, Procedure 300.60 has been revised to include updated requirements regarding subpoena issuance and language usage on the document. DCP continues the divisional review of Procedures 300 reformatted by the Office of Child and Family Policy. These recommendations have been added.

The Department needs to implement procedures for accessing underlying arrest reports to comply with Administrative Procedure 6. The Department should utilize the law enforcement liaison in the office of the Director when implementing these procedures (from OIG FY 06 Annual Report, Death and Serious Injury 11).

FY 06 Department Response: The committee continues work on revisions to Administrative Procedure 6 - LEADS Protocol. Issues leading to development of this workgroup have been incorporated into the current draft. The Illinois State Police reviewed a recent draft and their comments have been included. The Legal Division representative is reviewing the draft in light of the Adam Walsh Act to ensure appropriate provisions are included in the LEADS protocol. Anticipated completion of revisions should be by the beginning of 2007.

FY 07 Department Update: The Division of Child Protection worked with the Legal Division to revise and update the administrative subpoena (CANTS 7), which is on DCFS templates available for all staff.

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

Additionally, Procedure 300.60 has been revised to include updated requirements regarding subpoena issuance and language usage on the document. DCP continues the divisional review of Procedure 300 reformatted by the Office of Child and Family Policy. These recommendations have been added.

This report should be shared with the appropriate Department Administrator. The Administrator should review the report toward improving the Subsequent Oral Report (SOR) conference process in her area (from OIG FY 06 Annual Report, Death and Serious Injury 6).

FY 06 Department Update: The Division of Child Protection is in the process of evaluating SOR conferences across the state in an effort to standardize expectations, processes, etc., for all participants required to attend. The report was shared with involved staff.

FY 07 Department Update: A process memo was issued to staff in August 2007 regarding requirements for conducting these reviews.

While developing its protocol for investigations of abuse and neglect in religious facilities the Department should develop a general protocol for ascertaining supervisors and administrators for official notification. An appointed designee of the Department's Legal Division or the State Central Register should facilitate notification to the proper religious superiors (from OIG FY 06 Annual Report, General Investigations 9).

FY 07 Department Response: The Department is reviewing this recommendation.

Procedures for investigations of Cuts, Welts and Bruises should be amended to provide that when suspicious bruising is reported (indicative of fingerprints, implements or otherwise suspect based on developmental age of child or location of bruise), and investigator does not see the bruise, the reporter must be contacted prior to an initial safety CERAP determination (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 3).

FY 07 Department Update: The Office of Child and Family Policy has forwarded the final draft of Procedures 300 to the Division of Child Protection. The Procedures 300 workgroup is reviewing the final draft and expects completion by December 2007.

DCFS Procedure 300 should be amended to provide that the decision to take protective custody of a child whose parent is receiving services from the Department (e.g., intact family, independent living, or residential programs) must include consideration of the degree of the parent's cooperation with services and the extent to which services provided address the allegation (from OIG FY 04 Annual Report, Death and Serious Injury 19).

FY 04 Department Response: The CERAP Advisory Council is currently reviewing the CERAP Protocol. The OIG recommendations will be shared with the group at their next meeting. January 2005

FY 05 Department Update: Procedure 300.80 has been revised and the draft includes this consideration. Legal is currently reviewing Procedures 300 and it is projected all related tasks will be complete by the Spring 2006.

FY 06 Department Update: The Division of Child Protection Committee has not completed its review and final revisions to Procedures 300. Once completed, these will be returned to the Office of Child and Family Policy to begin the process of approval from JCAR. Implementation date: Spring 2007.

FY 07 Department Update: The Office of Child and Family Policy has forwarded the final draft of Procedures 300 to the Division of Child Protection. The Procedures 300 workgroup is reviewing the final draft and expects completion by December 2007.

The Deputy Director of Child Protection should develop a list of prompting questions that must be used in supervision of all investigations in which a physical injury is alleged. Use of this list should be required by Procedure 300 and be included in the investigative record. Questions should include, but not be limited to:

- **Have there been a series of injuries to child(ren) in the home in the last 6 months?**
- **Have there been any changes in household composition or caretaking that correspond with the onset of injury?**
- **If parents are separated or divorced, have both parents been contacted for information and/or placement?**
- **Has there been a delay in seeking care for any of the injuries?**
- **Were there any witnesses to the injury, if so, what did the witnesses report?**
- **Is the explanation for the injury consistent with the injury? Whose opinion is it and what facts were shared?**
- **Were conflicting explanations given for the injury? What were they and by whom?**
- **Are the injuries occurring only in one setting (e.g., home v. school or daycare)?**
- **Are the injuries occurring only with one particular caretaker?**
- **Have the factors allegedly causing the injuries occurred across settings?**
- **Was there corroboration for the explanations given for the injuries? What was it ? (from OIG FY 06 Annual Report, Death and Serious Injury 6).**

FY 06 Department Response: The committee convened to review and revise the safety assessment instrument and process and is still working on this project. The prompting questions will be included in the revisions. Target date: June 2007.

FY 07 Department Update: This information has been added to proposed revisions of Procedure 300.50. A policy and procedural memo was issued to staff in August 2007 regarding incorporating these questions into supervision of physical abuse investigations. Also issued in August 2007, a memo requiring incorporating these questions into the SOR/Serious Harms conference reviews process.

The Department's Medical Director should consult with local experts on child abuse about the prompting questions regarding what, when, and how the information should be shared when seeking an opinion from a doctor about physical injuries. Procedure 300 should be updated to include this (from OIG FY 06 Annual Report, Death and Serious Injury 6).

FY 07 Department Response: The Department will develop the guidelines.

Once developed, all child protection investigators, supervisors, and managers should be trained on the investigation prompting questions discussed above (from OIG FY 06 Annual Report, Death and Serious Injury 6).

FY 06 Department Response: The Department agrees. The Office of Training will incorporate the guidelines into the CORE Training when they are complete. Target completion date: September 2007.

FY 07 Department Update: The Department agrees. The Office of Training will incorporate the guidelines into the CORE Training when they are complete.

The body chart used in child protection investigations should be corrected to reflect current research on the dating of children's bruises. This information must be conveyed via training, including supervisor training (from OIG FY 06 Annual Report, Death and Serious Injury 6).

FY 06 Department Response: The Department agrees. Procedure 300 is under revision and this information will be included in the revisions. Training will follow completion of Procedure 300.

FY 07 Department Update: Child & Family Policy has forwarded the final draft of Procedure 300 to the Division of Child Protection. The Procedure 300 Workgroup is reviewing the final draft and will be completed by December 15, 2007. Training will follow completion of Procedure 300.

The Department's Procedural Guidelines for Investigation of Paramour Involved Families ("Paramour Policy") should be amended to include a determination of whether the paramour has any other children not living in the household and specifics about where and with whom they reside (from OIG FY 06 Annual Report, Death and Serious Injury 3).

FY 06 Department Response: The Department agrees. The Department will revise its policy to reflect changes in Paramour Policy (Procedures 300, Appendix H) regarding paramours' children.

FY 07 Department Update: Child Protection is currently revising the Paramour Policy and will send the draft to Child & Family Policy.

DCFS Rule 315, Appendix A should be amended to require a CERAP be completed when a parent who has an open DCFS case and whose children have previously been removed from his or her care has another child. The Teen Parent Service Network Policies and Procedures should be likewise amended (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 19).

FY 07 Department Update: The new CERAP draft currently being field-tested provides that a safety plan must be developed whenever a caregiver has a prior abuse history.

The Child Endangerment Risk Assessment Protocol (CERAP) should be amended to require that workers note when a risk factor cannot be answered because of insufficient information. Under such circumstances, workers should be required to perform diligent inquiry into relevant facts for assessment within 48 hours. The Department should develop tight procedures to ensure that there is follow-up and resolution of unknown variables (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 9).

FY 07 Department Update: The draft CERAP, currently being field-tested, addresses this recommendation.

The procedures for completing a Child Endangerment Risk Assessment Protocol (CERAP) should be amended so that the guidelines regarding a household member's developmental disability or

mental illness direct a worker to consider pursuing a dependency petition (from OIG FY 06 Annual Report, Death and Serious Injury 2).

FY 07 Department Update: The committee has developed a new safety assessment protocol, which is being field tested. The new protocol does not include a prompt to consider dependency.

The procedures for completing a CERAP and the decision tree for mentally ill parents should be amended so that the guidelines note the need to assess risk to the child when a parent incorporates a child into their delusional system, even in the absence of overt negative statements (from OIG FY 06 Annual Report, Death and Serious Injury 2).

FY 06 Department Response: The committee revising the safety assessment continues to work on the safety framework protocol. Targeted completion date is June 2007.

FY 07 Department Update: The new safety assessment that is being field tested does not include guidelines that address the need to assess risk when a parent incorporates a child into their delusional system.

CONTRACT MONITORING

The Department must immediately ensure that no further advance payments are issued without procurement of a surety bond and without signed verification that the expected billings and proposed budget will support timely repayment of the advance. Contract monitors must ensure that contractors are not incurring needless expenditures, such as the rental payments that the new agency incurred (from OIG FY 06 Annual Report, General Investigations 13).

FY 06 Department Response: The Division of Budget and Finance will work with the Office of Legal Services to develop an appropriate protocol for implementing a surety bond process as it relates to advance payments for non-board contracts.

FY 07 Department Update: Protocol development is in process. Anticipated completion date: May 2008

The Department must separately track all advance payments and ensure they are repaid in a timely manner (from OIG FY 06 Annual Report, General Investigations 13).

FY 06 Department Response: The Department's Office of Contract Administration and Office of Financial Management will work together to develop a separate tracking mechanism for advances made with non-board contracts. Estimated date of completion is February 28, 2007.

FY 07 Department Update: The tracking mechanism is under development. Anticipated completion date: May 2008.

The following recommendations are from the OIG FY 06 Annual Report, General Investigation 12:

1. The Department must develop a reliable Contract Monitoring process that would provide checks and balances and separation of functions to prevent the abuses identified in this Report. The process must include:

- Quarterly review of expenditures to ensure that expenditures were related to the Contract;
- Quarterly review of services, to ensure that the goods or services were provided;
- Contractual and Rule requirement that any contractual spending for services or items not specifically covered under the Contract must be approved, in writing, by the Contract Division;
- Lapsed funds and deobligation of funds must be approved in writing by the Contract Division.

2. The Department must develop specific guidelines for disbursement when Fiscal Agents are used. The guidelines must include checks and balances to ensure that Fiscal Agents ascertain that the services or goods for which they issue checks have been provided. The use of Fiscal Agents must also be monitored by the Contracts division to ensure separation of functions. Fiscal Agents must understand that their role is not limited to check-writing and that they maintain fiduciary responsibility for expenditure of public funds.

3. The Department needs to systematically track public monies spent by contractors through subcontracts. The Department must be able to track who is ultimately responsible for providing services and who is ultimately receiving DCFS funds, in order to guard against conflicts of interest and double-billing.

4. The Department must develop a conflict of interest protocol, whereby entities are identified that the Department should not be contracting with, because of conflicts of interest, and the Department must purchase anti-conflict software that would identify Department funds expended on prohibited entities, similar to the practice at law firms.

FY 06 Department Update: The Department is developing a workgroup that will consist of Contract Administration staff, Budget and Finance staff, and a representative(s) of the Conflict of Interest Committee to analyze the current processes and make recommendations to the Director for changes/enhancements.

FY 07 Department Update: Workgroup is being developed. Anticipated completion date: May 2008.

OIG Response: This recommendation was made after the Inspector General's Office discovered that a quarter of a million dollars of Department funds, intended to assist children and families was diverted into the private bank account of a department manager. These changes are critical to ensuring that such abuse of trust does not occur in the future. The Department has had over two years to institute these basic changes.

FOSTER HOME LICENSING

Determining who should get foster home licensing responsibility in split cases is a clinical decision that should not be made by DCFS Central Office of Licensing. When transferring or assigning child cases, the Department needs to first identify all children in the foster home and assign children's cases and licensing responsibility to receiving agencies. If on rare occasions a split

cannot be avoided, the Department's Case Assignment Unit, in conjunction with Purchase of Services Monitoring, should develop an individual agreement between the agencies on the role and monitoring duties of each agency with six-month clinical reviews (from OIG FY 04 Annual Report, General Investigation 1).

FY 04 Department Response: POS foster home licensing in a split case will be determined based on a clinical review process. POS will initiate discussions with the Clinical Division to insure the development of a uniform process for implementation. Meetings will be convened in January 2005 to develop a process. Implementation date: March 2005

FY 05 Department Update: Procedure revisions are in process.

FY 06 Department Update: Discussions on how to handle split cases are under review.

FY 07 Department Update: Policy transmittal 2006.07 is being reviewed by OIG for possible language changes to implement the recommendation.

OIG Response: The OIG prepared specific recommendations to address problems inherent in split case responsibility. The document provided does not address those recommendations.

DCFS licensing enforcement procedures must provide for immediate licensing revocation proceedings with findings of egregious licensing violations (from OIG FY 04 Annual Report, General Investigation 1).

FY 07 Department Update: Final revision of Rule 383 was submitted for approval. The Joint Committee on Administrative Rules process has not been completed. The Director's Office will review further. Target date for completion: March 2008.

Procedures 383, Licensing Enforcement, should be amended to include substantive guidelines on conducting licensing complaint investigations. Currently, the Procedures focus on the concurrent licensing investigations initiated as a result of CANTS allegations. The Procedures do not address issues such as the standard of determination, interviewing requirements, verification of self-report information, assessing credibility, or when an unfounded DCP investigation should trigger a licensing investigation. Additionally, the Department must clarify who has the responsibility for conducting the licensing complaint investigations (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 22).

FY 07 Department Update: Final revision of Rule 383 was submitted for approval. The Joint Committee on Administrative Rules process has not been completed. The Director's Office will review further. Target date for completion: March 2008.

As previously recommended in a July 2003 OIG report, the Department should amend Procedure 402 to require that prior to licensing monitoring visits, foster home licensing staff communicate with the caseworkers of children currently placed in the foster home. The purpose of the meeting would be to assist the licensing worker in becoming more familiar with the home, reviewing services provided the foster children in their care, and to allow caseworkers to raise any concerns about the home or the care of the children (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 22).

FY 07 Department Update: With the OIG's recommendations, Procedures 402 was finalized and issued on June 25, 2007.

The Department should immediately issue a policy clarification for Rule 402.15 regarding the number and ages of children permitted in licensed foster homes. The clarification memo should emphasize that all children receiving full time care in the home - birth, adopted, foster and otherwise - are to be figured in to the total (from OIG FY 06 Annual Report, Death and Serious Injury 8).

FY 07 Department Update: Draft has been revised and will be submitted to licensing for review by November 15, 2007. Target completion date: January 2008

The Department should prohibit ongoing management of split cases among private agencies. When consolidating a split case, the agency that has the licensing responsibility should be considered for full case management responsibility. The agency that relinquishes foster children through case consolidation should not be penalized and should be moved up for case assignment. Under extenuating circumstances, such as a caseworker's long-term relationship with assigned foster children, a waiver could be issued by Agency and Institution Licensing managers based on a presentation of the circumstances at a staffing that must take place at the licensing agency. For each waiver granted, an Agency and Institution Licensing representative must attend a case staffing (from OIG FY 06 Annual Report, Death and Serious Injury 4).

FY 06 Department Response: This recommendation will be discussed at a future meeting between the Director and the OIG.

FY 07 Department Update: OIG is reviewing policy 2006.07 for possible language change to be in compliance with and implement this recommendation.

OIG Response: The OIG prepared specific recommendations to address problems inherent in shared foster home responsibility. The document provided does not address those recommendations.

GENERAL

When a home study is requested through Interstate Compact, the request should include asking the local child welfare worker conducting the home study to check with local law enforcement authorities whether they have any history on the household in addition to the criminal background check with the State Police (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 13).

FY 04 Department Response: Revisions were drafted and shared with the OIG and should be finalized by March 2005.

FY 05 Department Update: The plan and budgetary issues are still in process. This could be implemented if the extra background check is limited in scope.

FY 06 Department Update: The Interstate Compact Workgroup is currently reviewing all Interstate Compact procedures. This recommendation will be included in their review. Implementation date: July 2007

FY 07 Department Update: This has been resolved with the issuance of Policy Guide 2007.05 on June 13, 2007. Included in this Policy Guide is a standardized Interstate Home Study Outline that incorporates this recommendation.

The Department should develop a policy concerning soliciting clients for legislative activity (from OIG 06 Annual Report, General Investigations 25).

FY 06 Department Response: A draft policy was submitted to the Deputy Director of Legislative Affairs for review and final approval October 26, 2006.

FY 07 Department Update: Upon further review, the Department does not agree with this recommendation.

OIG Response: This recommendation arose after the Inspector General's Office investigated a complaint it received that foster parents from DCFS and private agencies were being contacted and asked to travel to Springfield on buses to support a legislative proposal for subsidized medical care for Illinois families. There was no determination that the families contacted would benefit from the legislative proposal and Department staff time and resources were allotted to advocate for the proposal even though it was not a program directly related to the primary work of the Department. The Ethics Board determined that such contact could cause foster parents to fear retaliation if they refused or to expect a benefit if they participated. The Board determined that the contacts could have the appearance of exploiting the foster parents dependence on the monitoring agency to further a political agenda. This recommendation had been accepted in June of 2006.

The Department should review and update the Emergency Reception Center Manual to include expectations of follow-up workers bringing children to the Emergency Reception Center (from OIG FY 06 Annual Report, General Investigations 4).

FY 07 Department Update: The Updated ERC Protocol/Manual (Transmittal) has not been finalized and is on hold with the Office of Child and Family Policy awaiting information resolution regarding shelter transportation issues. When it is completed the informational transmittals will go out to DCFS, POS, CWS, and DCP staff. Also training will take place for all staff regarding protocol on how CWS or DCP can make an Emergency Shelter referral and intake guidelines for bringing Children/Youth into ERC for an emergency temporary shelter care placement.

When a medical report indicates that a caregiver, regardless of age, may not be capable of caring for a child into adulthood, the back-up caregiver should sign a statement that he/she is aware of that fact and is still willing to serve as the back-up caregiver (from OIG FY 05 Annual Report, General Investigation 19).

FY 07 Department Update: Revisions to Rule 309 Adoption Services have been made by the Office of Child and Family Services and it is under review. Target completion date is March 2008.

Children with increased vulnerability, either because of age or developmental disabilities, who present with a medical condition that could be the result of sexual exploitation, should be referred to the local child advocacy center for a victim sensitive interview to assist in determining if the medical condition is the result of abuse (from OIG FY 06 Annual Report, Death and Serious Injury 3).

FY 06 Department Response: The Department agrees. A memo will be distributed to staff regarding this issue.

FY 07 Department Update: A memo is currently being revised and should be distributed by January 2008.

The Department must immediately implement the OIG's previous recommendations for the Sexually Aggressive Children and Youth program made in FY 2000 and accepted by the Department (from OIG FY 04 Annual Report, General Investigation 21).

FY 07 Department Update: Revised Procedure 302.240 was issued January 25, 2007.

Solicitation and acceptance of case and in-kind donations should be coordinated by the Office of External Affairs which could make sure that solicitation efforts throughout the State are handled consistently and avoid conflicts of interest. The Office could also coordinate the receipt and distribution of physical items to make sure that they are distributed.

FY 07 Department Update: Solicitations of donations for the Agency are all handled by the Division of Communications.

The DCFS consent form for release of information of a child's medical records should specify HIV test results for all substance exposed infants and children (from OIG FY 05 Annual Report, General Investigation 14).

FY 07 Department Update: Staff from the Guardian's Office, Legal Services, HIV/AIDS Unit and Health Services developed HealthWorks procedures for HIV screening. These procedures were reviewed and approved by the Medical Issues Workgroup, which includes Guardian, Medical Director and Deputy Directors of Clinical and Service Intervention. HIV/AIDS Unit and Health Services staff provided training re: the procedures on August 27, 2007 to HealthWorks Lead Agencies. The CFS 600-3 form that HealthWorks Lead Agencies use to request information includes an explicit reference to HIV screening results.

The OIG recommended that Rule 412 be revised:

- **To permit the Department to refuse to issue a license with knowledge that the applicant had committed a violation that would warrant revocation or if the applicant had engaged in behavior that would pose a risk to children or state resources;**
- **To expand the list of criminal pending charges or convictions that would warrant a refusal to issue to include any crime of which dishonesty is a essential element;**

- **To permit the Department to refuse to issue a license if the applicant provides false information during the licensing process;**
- **To provide guidelines for assessing criminal convictions and abuse or neglect findings that are not bars to licensure;**
- **To permit the Division of Child Welfare Employee Licensure to refer applications for investigation to verify facts presented (from OIG FY 06 Annual Report, General Investigations 26).**

FY 07 Department Update: The Clinical Division, through the Child Welfare Employee Licensure (CWEL) staff, has drafted proposed changes to Rule, Part 412. The draft of the proposed amendment incorporates input from the OIG, and the appointed Board members of the Child Welfare Employee Licensure (CWEL) program. The text of the proposed amendment will be submitted to the Director for review, approval, and transmittal to the Joint Committee on Administrative Rules (JCAR).

The Department’s Conflict of Interest Committee should establish procedures for building walls between private agencies and DCFS Administrators who have decision-making power over agencies that they previously worked for (from OIG FY 06 Annual Report, General Investigations 28).

FY 06 Department Response: The procedures have been drafted by the Conflicts of Interest Committee.

FY 07 Department Update: The Director is considering the recommended changes.

The Department should seek the advice and training of the National Association of Administrative Law Judges on conflicts of interest in the reporting structure (OIG FY 06 recommendation omitted from prior Annual Report).

The Director should have the benefit of General Counsel’s advice in determining whether to accept, reject or modify an ALJ recommendation (OIG FY 06 recommendation omitted from prior Annual Report).

FY 07 Department Update: The OIG will set-up a meeting with the National Association of Administrative Law Judges, OIG staff and Department staff.

MEDICAL

The Guardianship Administrator’s Office should regularly obtain information from Medicaid Prescription Use Screens to better service wards who are prescribed multiple medications (from OIG FY 06 Annual Report, General Investigations 4).

FY 06 Department Response: The Department’s consulting psychiatrist has been in discussions with staff from DHS, regarding linking the DCFS Psychotropic Medication Consultation Program database and the IDPA Medication Screens to provide more timely access to Medicaid Payment Data.

FY 07 Department Update: DHS General Counsel is working to secure approval. After approval is secured, DCFS Legal will work to secure the signatures required to implement the Intergovernmental Agreement. Anticipated completion date: May 2008.

OIG Response: The Intergovernmental Agreement addresses only access to records of psychotropic medication and only for wards that the Department is unable to locate. This does not address the recommendation, which was to monitor multiple medications of all wards. It should not be limited to wards who cannot be found, and it should not be limited to psychotropic medications, since non-psychotropic medications can be counter-indicated for use with psychotropic medications.

Wards diagnosed with juvenile diabetes should receive medical treatment through pediatric endocrine clinics to benefit from specialized medical care, i.e., pediatric endocrinologist, developmental ophthalmology specialist, retinal specialist, and development and implementation of individualized Diabetic Care Plans (from OIG FY 04 Annual Report, General Investigation 12).

FY 04 Department Response: Wards with juvenile diabetes can receive their routine medical treatment through their primary care physician. Their specialty care will be overseen by a pediatric endocrinologist, who would make the necessary subspecialty referrals. The child's primary care physician will make the specialty care referral to the pediatric endocrinologist. Regional nurses can also assist caseworkers with locating pediatric endocrinologists. Reference to this will be included in the draft nurse referral policy guide, which will be finalized for submission to the Office of Child and Family Policy by January 2005.

FY 05 Department Update: Reference to regional nurses assisting with finding specialty medical providers (e.g. pediatric endocrinologists) was included in the draft nurse referral policy guide sent to the Office of Child and Family Policy in April 2005. Division of Service Intervention-Health Services staff have been participating in meetings of the medically complex protocol committee. This committee is chaired by the Division of Child Protection. Several meetings were held throughout the summer and fall. A final draft has been circulated to committee members for their review and comment. Once this draft is finalized and ready for submission to the Office of Child Family Policy, Division of Service Intervention-Health Services staff will meet with Office of Child and Family Policy staff, DCFS Medical Director, Clinical and others to determine what changes are required to the draft nurse referral policy guide.

FY 06 Department Update: The draft protocol has been provided to the OIG for review. They will provide comments to the draft in January 2007.

FY 07 Department Update: Child & Family Policy has formatted the final draft version of Children with Special Health Care Needs - Draft Appendix L and Procedures 302, Subsection 302.388(f)(10). A D-Net announcement will announce the 800 number for nursing referrals statewide once the number is activated.

The Department nursing staff, when asked to consult on a medically complex child, should conference with other medical professionals as part of the consultation and ensure the caseworker has established communication with the medical professionals involved in the child's care (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 10).

FY 07 Department Update: Child & Family Policy has formatted the final draft version of Children with Special Health Care Needs - Draft Appendix L and Procedures 302, Subsection

302.388(f)(10). A D-Net announcement will announce the 800 number for nursing referrals statewide once the number is activated.

The Department should require intact family caseworkers to meet with medical personnel when a child in the family has a chronic medical condition (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 10).

FY 07 Department Update: Child & Family Policy has formatted the final draft version of Children with Special Health Care Needs - Draft Appendix L and Procedures 302, Subsection 302.388(f)(10). A D-Net announcement will announce the 800 number for nursing referrals statewide once the number is activated.

The Department, as recommended in a previous report, should apply a targeted feeding assessment, such as the Nursing Child Assessment Satellite Training, in cases with allegations of inadequate food and/or malnutrition and failure to thrive and where there are chronically ill children whose feeding regimen may require occupational therapy adaptations (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 10).

FY 07 Department Update: Comments are being incorporated into the draft procedures for medically complex, including children with feeding problems.

Because of the increased complexity of technology-dependent children, the Department's protocol for investigations of medically complex cases must include a standard of investigation that addresses:

- **Situations where the reporter of the hotline call is a home health professional working in the family's home. Because multiple parties are involved in the child's care in the home, and in an effort to minimize bias possibly rooted in relationship conflict, the child protection staff should be expected to get an independent medical evaluation to help determine abuse or neglect. It is necessary to have an expert opinion outside of the opinion and evaluation of the family's nursing agency in order to minimize bias possibly rooted in relationship conflict. The independent medical assessment should take into account the comparative risks and benefits of home care and out-of-home care for each child under the circumstances of each case.**

- **Child protection staff investigating families involving children with a Home Waiver should make it standard practice to (1) identify the family's UIC Division of Specialized Care for Children (DSCC) Care Coordinator as a primary source of historical and current information regarding the child, family, the child's care, the home environment, the parents' relationship with health care professionals, and (2) request the DSCC Guidelines to understand the parent-service provider relationship, including role boundaries and parental rights.**

This report should be shared with the Division of Child Protection Administrator, who is the Chair of the work group that is developing a protocol for investigations involving medically complex children (from OIG FY 05 Annual Report, General Investigation 13).

The Department's draft definition of "medically complex" or "medically fragile" children should be consistently applied in rule, procedures and policy, and in all documents that refer to medically complex children (from OIG FY 05 Annual Report, General Investigation 13).

The Department should amend Procedure 300.80 Taking Children into Protective Custody to include a section on Medically Complex Children detailing:

- Procedures to enable workers to arrange for transport of medically complex children to the most appropriate HealthWorks facilities that can accommodate technology-dependent children and are equipped to handle the child's needs during the initial health screening and admission, unless it is a medical emergency situation. Children with a severe disability or medical condition are referred to a specialist for evaluation and treatment.
- Children ages 30 days old to 18, with a history of severe medical conditions should have special arrangements made to prepare for taking protective custody. The DCP investigator should involve a DCFS registered nurse to assist with planning and preparation to take protective custody, including but not limited to, securing the child's care plan to follow the child, transportation arrangements, hospital admission, and placement issues.
- Primary care providers must be interviewed when considering protective custody, and the interviews should be specific to reported allegations. If possible, child protection workers should ask the primary care physician for a home visit or assessment of the circumstances.
- When a DCFS nurse recommends review of medical information or identifies sources to interview, the recommendations must be followed prior to concluding an investigation (from OIG FY 05 Annual Report, General Investigation 13).

FY 07 Department Update: Child & Family Policy has formatted the final draft version of Children with Special Health Care Needs - Draft Appendix L and Procedures 302, Subsection 302.388(f)(10). A D-Net announcement will announce the 800 number for nursing referrals statewide once the number is activated.

The draft Policy Guide 2005: Referrals to DCFS Regional Nurses should:

- Require that DCFS nurses be immediately consulted in investigations of medically complex children.
- The suggested five-day referral response time should not apply to investigations of medically complex children; instead, the response should be immediate.
- Require that medical records be retrieved in an expedited manner (from OIG FY 05 Annual Report, General Investigation 13).

FY 07 Department Update: Child & Family Policy has formatted the final draft version of Children with Special Health Care Needs - Draft Appendix L and Procedures 302, Subsection 302.388(f)(10). A D-Net announcement will announce the 800 number for nursing referrals statewide once the number is activated.

The Department should review all HealthWorks medical providers statewide to determine which ones are equipped to handle children with special needs and ensure that child protection staff utilize HealthWorks providers accordingly (from OIG FY 05 Annual Report, General Investigation 13).

FY 07 Department/OIG Update: On further discussion with the Medical Director of the Department, the OIG recognizes that the ultimate decision regarding which hospital a child will be taken to will be made by the ambulance services. The Department agrees that workers will be required to notify the ambulance service of all special care needs of the child.

PERSONNEL

The Department should develop policy to address suspected substance abuse in the workplace (from OIG Recommendations made in 05, 01 and 99).

FY06 Department Response: The Department developed a definition and procedure for Reasonable Suspicion testing. The Department agrees to amend the Employee Manual and the Employee Licensure Rule to address Reasonable Suspicion of substance abuse and will also engage in discussions with the union.

FY 07 Update: The Department's workgroup addressing the need for incident-based reasonable suspicion drug or alcohol testing is currently developing protocol for pre-employment drug testing. Reasonable suspicion testing has been put on hold temporarily.

The Department's Division of Legal Services should review the Office of Employee Records and Payroll's current practices of responding to employee reference checks (from OIG FY 06 Annual Report, General Investigations 15).

FY 07 Department Update: The checklist is currently under review by Legal who will consult with Central Management Services. Target completion date: March 2008.

The Department's Clinical Division should develop a protocol on the utilization, monitoring and supervision of student interns (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 2).

FY 07 Department Update: The Division created and implemented (through the Office of Training) a central internship coordinator for all DCFS internships. All new interns are given orientation training at the time of their assignment. The Internship Program Coordinator maintains communication and coordinates supervision between the intern, the College or University, and the sponsoring DCFS Office or Division with whom the intern is assigned.

All Department supervisors should have access to the Internet for evidence-based research to develop a knowledge based on relevant issues (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 9).

FY 07 Department Update: This option was implemented in December 2006. A form is available on the D-Net for staff to request internet access (OITS/Security/Security Forms).

The Department should incorporate into its training and Employee Manual the qualification that in order to trigger the ex parte communication reporting requirements for pending rulemaking, the

employee should reasonably believe that the contactor is intending to influence the rulemaking process (from OIG FY 06 Annual Report, General Investigations 27).

FY 06 Department Response: Revisions have been approved for inclusion in the next revision of the Employee Handbook. Anticipated time frame: December 2006.

FY 07 Department Update: This information will be included in the next revisions of the Employee Handbook. Target completion date: June 2008.

The Department should consider a reasonable use exception for private (non-political) use of the fax machine to conform to the reasonable use exception for telephone use (from OIG FY 06 Annual Report, General Investigations 27).

FY 06 Department Response: Labor Relations has provided the Director's Office with a draft and it is currently being reviewed. Implementation date: December 2006.

FY 07 Department Update: Upon further review of this matter, it has been decided that it would not be in the best interest of the Agency to facilitate such a policy.

OIG Response: *The OIG does not believe that limited or emergency use of facilities, such as faxing a consent for a school trip, should be treated as misconduct.*

PRIVATE AGENCY MONITORING

The Department should develop procedures for APT monitoring of agencies and APT monitors should be trained to competently carry out monitoring responsibilities. Procedures should provide guidelines for, but not be limited to, substantive reviews of children's case records, verification of agency compliance, reviews of foster parent license files when necessary, development of corrective action plans, and formal exchange of information with other monitoring units of the Department's POS Monitoring Division (Agency and Institution Licensing, Office of Field Audits, Contract Compliance Unit) to achieve an integrated assessment of a private agency for appropriate action (from OIG FY 05 Annual Report, General Investigation 14).

FY 05 Department Response: The Department has standard operating Procedures for APT monitoring of agencies, and training is extended to APT staff on new initiatives, and on a necessary basis. A monitoring guide was drafted for Cook POS monitoring and is awaiting review and approval of the Deputy Director. The anticipated date of publication: January 31, 2006. The monitoring guide for downstate is still in draft form. The anticipated release date: June 30, 2006. Competent reviews of foster home files are to be conducted by licensed and certified licensing staff. A monthly Associate Deputy Directors meeting is primarily meant for information sharing, and developing intra unit action plans.

OIG Response: *The OIG reviewed the draft APT Monitoring Guide and found it is a compilation of forms and does not, as of yet, include any substantive procedures or guidelines for monitoring private agencies. The OIG will work with the Department in further developing the guide.*

FY 06 Department Update: The Cook monitoring manual was completed and a copy was given to the OIG. The monitoring guide for downstate will be completed when staff is hired in vacant key administrative positions. Anticipated completion date: January 30, 2007.

OIG Response: As noted in the prior annual report, the manual received by the OIG does not include substantive procedures or guidelines.

FY 07 Department Update: The OIG has been provided with a copy of the new protocols. Agency Performance is primarily done with the newly designed monitoring tools.

OIG Response: The Agency Performance Teams are designed to review specified identifiable outcomes: Parent/sibling visitation, Education, Step-up, Integrated Assessments and Family Meetings.

The Department's Licensing Standards for Child Welfare Agencies (Rule 401) and Child Care Institutions (Rule 404) should be amended to prohibit familial relationships between the Executive Director and Financial Officer/Accountant at the same agency (from OIG FY 05 Annual Report, General Investigation 4).

FY 07 Department Update: This recommendation has been incorporated into both rules. (Rule 401.210(d)(3)(D) - February, 2006; Rule 404.9(b)(4) - March, 2007.)

STATEWIDE AUTOMATED CHILD WELFARE INFORMATION SYSTEM

The SACWIS system should be modified so that the system has the necessary data to be capable of (1) identifying foster parents when their name is entered into the 'Person Search' option and (2) notifying a foster care licensing agency when the State Central Register receives a report on a foster parent or foster home. Although this report does not involve identification of private agency employees, modification of the SACWIS system should include identification of private agency employees because of DuPuy (from OIG FY 06 Annual Report, Death and Serious Injury 4).

FY 06 Department Response: It has been determined that the recommendation requires implementation of the Licensing and Resource systems which was scheduled for Phase III of SACWIS. Phase III is currently on hold due to a lack of available resources.

FY 07 Department Update: It has been determined that the recommendation requires implementation of the Licensing and Resource systems which was scheduled for Phase III of SACWIS. Phase III is currently on hold due to a lack of available DCFS resources and funding.

OIG Response: This recommendation was made after a ward of the Department was killed in a foster home that had been recently investigated for physical abuse. The foster care agency was unaware of the prior investigation because the prior investigation had involved the biological son of the foster mother's paramour. The Department had not known at the time that the woman was a foster parent and the other child in the home was a ward. The OIG reiterates the importance of making this minor change to the SACWIS system that could increase child safety.

The OIG reiterates its previous recommendation that the SACWIS program be adjusted to enable child protection managers to access investigators' rationales for requested waivers on a "read only" basis after investigations are closed. When there are unfortunate outcomes, management needs to be able to review the appropriateness of the entire investigation for learning purposes (from OIG FY 06 Annual Report, Death and Serious Injury 4).

FY 07 Department Update: The change was implemented December 17, 2006.

SUBSTANCE ABUSE ISSUES

Illinois Substance Abuse Waiver Demonstration project staff should be trained on providing integrated services to clients that address the family's well being and emphasize parental involvement while children are in foster care. Parents should be supported in establishing relationships and taking an active role with their children's school and pediatrician. The OIG Project Initiatives staff can convene this training using a redacted copy of this report, a status and outcome assessment developed for the Department and Indicators for Progress in the Substance Abuse Recovery Process (from OIG FY 06 Annual Report, Death and Serious Injury 10).

FY 07 Department Update: OIG and Service Intervention staff provided training to the Recovery Coaches. Additional training on the Recovery Matrix by OIG staff has also been scheduled.

The Illinois Department of Human Services recognizes that for cases in which the permanency goal is return home, federal zero to three programming is available to assist biological parents. Emphasizing treatment in a natural setting, DHS services should be accessed to assist both biological parents and foster parents. The Substance Abuse Waiver Demonstration project staff should receive training specific to zero to three services available for children and their families. The Department's Office of Training and Development should post information about such services on its training web site (from OIG 06 Annual Report, Death and Serious Injury 10).

FY 07 Department Update: The content for this training is complete and has been given to the Center for the Application of Information Technologies (CAIT) for web development. The web-based component will be developed and ready for use by December 31, 2007.

In split custody cases with a history of substance abuse and relapse, the Department should require random drug drops to assist the Department in securing necessary services for the children and family. In cases of alcoholism, random urine testing is not reliable. Breathalyzers are preferable. The OIG reiterates its prior recommendation that DCFS acquire breathalyzers and train on their use (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 21).

FY 07 Department Update: The Department has implemented new substance affected family policies that include drug testing requirements. Staff are being trained on the procedures as part of the Reunification training. An inter-division work group is developing additional guidelines for drug testing DCFS clients and monitoring DCFS drug testing contracts. The work group is developing standards for frequency and duration of drug testing, use of breathalyzers, and the panel of drugs to test. Anticipated completion date is the fourth quarter of FY-2008.

TEEN PARENT SERVICE NETWORK

Pregnant or parenting teen wards that continue to be involved in domestic violence situations should not be allowed to remain in an independent living apartment if the ward continues to remain in a violent relationship. The Teen Parent Service Network and DCFS need to develop and make available specialized crisis foster placements that can accept a teen parent and his or her children on an emergency basis while an emerging, potentially violent situation is de-escalated and

the safety and well-being of the parent and child is protected. As part of a CERAP plan in a situation where a pregnant or parenting teen ward continues in a domestic violence situation, if it is necessary for the parent to attend domestic violence counseling and participate in aggression replacement treatment (involving social skill, anger management and moral reasoning programming), the parent and child/ren should remain in the specialized crisis placement or other least restrictive setting that has 24-hour supervision until the parent successfully completes the individualized violence reduction treatment program (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 19).

FY 07 Department Update: These recommendations and redacted copies of this report were sent to the committee reviewing CERAP.

The Department should ensure that, once the Teen Parenting Service Network (TPSN) is notified by Unusual Incident Report of a pregnant or parenting ward who is 14 years of age or younger, TPSN must arrange for Title X counseling of that ward within forty eight hours (from OIG FY 05 Annual Report, General Investigation 10).

FY 07 Department Update: The intake department provides information about contacting *Planned Parenthood* and/or *The Cradle* to have a discussion about options counseling if the worker is uncomfortable about having this discussion. Any youth referred to the network under the age of 15 is immediately referred to The Advocacy Center for counseling, which can include options counseling as well. TPSN also has a nurse on staff available to get involved in options counseling when needed.

Teen Parent Service Network (TPSN), workers should be trained to: use the psychosocial assessment tool; be proficient at identifying stable and changing risk and protective factors; develop a specific parenting plan that builds on teen parents' social support and positive parenting skills; and monitor the progress of treatment to identify areas of weakness and deficiency (from OIG FY 05 Annual Report, General Investigation 26).

FY 07 Department Update: Teen Parent Service Network workers are trained to use the Integrated Assessment and the risk factors that are a part of that. Teen Parent Service Network also uses the Ansell Casey Pregnant and Parenting Teen assessments. All cases have eco maps used to identify social supports and after they are identified the supports are invited to attend and participate in family team meetings and are encouraged to assist the teen parent any way they can. The monitoring of progress towards treatment occurs by monitoring the service plan and by way of family meetings.

In cooperation with the National Alliance for the Mentally Ill (NAMI), supportive psychoeducational and peer support programming should be developed for teen parents with Major Depression, Bipolar Disorder, and other psychotic disorders. Staff from NAMI have offered to work with the teen parent initiative to set up and pilot a short-term psycho educational mental health and peer support group for appropriate teen parents with mental health problems (from OIG FY 05 Annual Report, General Investigation 26).

FY 07 Department Update: The Department will work with the National Alliance for the Mentally Ill (NAMI), regarding supportive psycho educational and peer support programming for teen parents with Major Depression, Bipolar Disorder, and other psychotic disorders.

Family mediation sessions should be initiated for teen-parent families to specify the voluntary terms of alternative or back-up caregiver arrangements (from OIG FY 05 Annual Report, General Investigation 26).

FY 07 Department Update: Teen Parent Service Network workers are trained to use the Integrated Assessment and the risk factors that are a part of that. Teen Parent Service Network also uses the Ansell Casey Pregnant and Parenting Teen assessments. All cases have eco maps used to identify social supports and after they are identified the supports are invited to attend and participate in family team meetings and are encouraged to assist the teen parent any way they can. The monitoring of progress towards treatment occurs by monitoring the service plan and by way of family meetings.

The Department should convene a panel of psychiatric, medical and child welfare practice clinicians to develop special criteria for assessing risk to children of wards where there are underlying conditions and a pattern of behavior by the parent that are problematic but have not yet resulted in abuse or neglect. The panel should consider recommending use of specialized counseling to determine the ward's desire to continue parenting or the use of the dependency provisions of the Juvenile Court Act to screen children of wards into court when the special criteria of risk specified by the panel are met (from OIG FY 05 Annual Report, General Investigation 26).

FY 07 Department Update: In Cook County the Department and TSPN supplements the battery of assessments used with all wards with several specialized assessments for parenting (Parenting Assessment Capacity, Adult Adolescence Parenting Inventory and the Parenting Capacity Checklist). TSPN has also enhanced their clinical program for the teen parents adding Mentors (some are DCFS alumni), family support workers, trauma therapist and alternative therapist (part-time therapist offering services such as yoga, and massage therapy between mothers and babies, and music therapy) for a holistic service base.

Five agencies provide Downstate services to pregnant and parenting wards. These services include individual counseling, parenting and education support, health care education, family planning and options counseling. The service base allows for observations of the parenting skills, their living situations and the dynamics for each young parent. Services require at least weekly in-person contact with the parent, twice monthly contact with the ward's child(ren), and contact with the teen parent's substitute caregiver twice a month. In addition, the teen parent and their children can receive services available through DHS and other community programs such as Teen Parenting Services and WIC services.

The Department is also reviewing the possibility of developing a Pregnancy Prevention program, which would include early training for all case carrying workers.

APPENDICES

APPENDIX A: Sacha Webber Investigation

APPENDIX B: Caleb Thomas Death Investigation

OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

REDACTED REPORT

The Office of the Inspector General is releasing this report for training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names, except those of professional references, are fictitious.

File: 06-0420

Children: Robert Thicke (DOB 7/1998)
Brianna Childs (DOB 2/1996)
Anita Banks (DOB 9/2000)

COMPLAINT

The Office of the Inspector General received a complaint that the police arrested licensed foster mother, Sacha Webber, for domestic battery of a child. Ms. Webber was a licensed foster parent through Alpha Agency and had three foster children placed in her home. On August 7, 2005, the State Central Register received a hotline call from the County Sheriff's Department. An officer had responded to a complaint that Sacha Webber fought with her foster children. The sheriff found seven-year-old Robert in his bedroom wearing urine soaked clothing. Ms. Webber made Robert clean up his own urine with a bucket of Lysol. Robert did not have a bed and nine-year-old Brianna, another foster child in the home, had scratches on her arm. The sheriff felt the children were not in a safe environment. The hotline received a second phone call five days later on August 12 from an anonymous reporter that Robert slept on a bare floor with no covers because he wet the bed. The reporter also alleged that the foster mother made Robert stay in his room for hours and recently struck Robert with a board on his buttocks and legs, causing bruises. The Division of Child Protection opened an investigation, Sequence G, on Sacha Webber for allegations of inadequate supervision, environmental neglect, cuts/bruises/welts, and substantial risk of physical injury.

INVESTIGATION

Home of Sacha Webber

Omega Agency initially licensed the foster home of Sacha Webber with a capacity for four children in September 1998. According to the licensing study Kenneth Evans had lived with Ms. Webber for the past six years. Ms. Webber and Mr. Evans had two children together, Maria (DOB 2/1995) and Kimberly (DOB 8/1999). Ms. Webber stated she wanted to foster parent because she had been placed in relative foster care as a child and wanted to help other foster children.¹ Ms. Webber obtained a high school diploma and attended community college classes. Ms. Webber worked at ABC Hospital from 3 p.m. to

¹ According to CYCIS, Sacha Webber became a ward of the state in November 1981 for abuse. The state closed her case in September 1984 under a court ordered release. Ms. Webber lived with her maternal grandmother and maternal aunt while in foster care.

11 p.m. as a Certified Nursing Assistant. Mr. Evans completed high school and had worked as a meat cutter and material handler. Ms. Webber and Mr. Evans reported an annual income of approximately \$21,600. According to the home study, both parents planned to handle the discipline of the children. The forms of discipline included time outs, sending a child to their room and having a child stand in the corner. According to Ms. Webber, she found potty training to be the most difficult part of parenting and would have difficulty with a child who intentionally destroyed things.

Over the next eight years, Ms. Webber provided foster care to nine children through Alpha Agency and Omega Agency (See Table One). In December 2002 the Division of Child Protection investigated Ms. Webber for allegations of cuts, bruises and welts to Vernon Samson, a foster child placed in her home by Omega Agency. DCP indicated the allegations against Ms. Webber. Omega Agency subsequently removed Vernon from the home, but allowed four year-old Robert to remain in Ms. Webber's care. Also, Alpha Agency allowed two year-old Anita and six year-old Brianna to remain in the home and did not pursue revocation of Ms. Webber's foster home license. Over the next two-and-a-half years, DCP investigated six additional hotline calls made against Ms. Webber, culminating in the removal of three foster children, her own two children and her niece.²

Table One: Children Placed with Sacha Webber³

Child	Agency	Jan- June 1999	July- Dec 1999	Jan- June 2000	July- Dec 2000	Jan- June 2001	July- Dec 2001	Jan- June 2002	July -Dec 2002	Jan- June 2003	July -Dec 2003	Jan- June 2004	July -Dec 2004	Jan- Aug 2005
Vernon Samson	Omega Agency								Patterned					
Matthew Samson														
William Samson														
Diana Samson														
Robert Thicke										Patterned				
Justine Thicke														
Brianna Childs														
Anita Banks	Alpha Agency													
Rick Bryant														
Erica Smithe		N/A												

² See Appendix 1 attached to this report for a complete summary of hotline calls involving Sacha Webber.

³ Full shaded cells represent placements for the majority of the six-month period. Patterned cells indicate placement for a shorter period of the six months.

Foster home license transferred to Alpha Agency

In July 2000, Ms. Webber requested that her license be transferred to Alpha Agency because Omega Agency did not meet her expectations and she did not feel comfortable with the biological mother of her foster children coming to her house.⁴ In August 2000 Alpha Agency took over monitoring the foster home and Jamie Fredrick (Alpha Agency) monitored Ms. Webber's home over the next five years. Ms. Fredrick told OIG investigators that she attempted unannounced visits if in the area, but that was difficult because of the distance.⁵ She requested Ms. Webber provide different days of the week for availability and tried to visit on those days. Ms. Fredrick stated she spoke to the foster children when they were home and Ms. Webber never resisted her home visits.

First DCP Investigation – September 2000

On September 6, 2000, Ms. Webber contacted Omega Agency and reported that two-year-old Robert went to the emergency room after he fell. According to the foster mother, Robert landed wrong when he came down the slide in the backyard and broke his upper left arm. One week later Ms. Webber called the case manager and reported that she was being investigated by DCFS because of the type of break Robert sustained. According to the health summary completed by the case manager for the client service plan, Robert had a spiral fracture of the left humerus. The Omega Agency case record did not contain any further information about this incident, including any follow up with the doctor or Division of Child Protection (DCP) by the Omega Agency case manager. There is no information on SACWIS about a hotline call made regarding Robert's broken arm or a subsequent investigation. Omega Agency removed Robert from Sacha Webber's home for one week in November 2000. Neither the Omega Agency case record nor the Alpha Agency licensing file contained any information regarding the reason for Robert's removal and subsequent return to the home.

Developmental Therapist voices concern regarding Robert's treatment in the foster home

In May 2001, Robert's developmental therapist reported to the Omega Agency case manager, Kelly Smith, that every time they went to the home Ms. Webber had three-year-old Robert in his room with the gate up.⁶ The case manager documented that she planned to monitor how much Ms. Webber had Robert in his room.⁷ The Omega Agency case record did not contain any documentation that Ms. Smith in fact monitored the time Robert spent in his room. In her interview with OIG investigators, Ms. Smith told OIG investigators that Ms. Webber sent Robert to his room as a form of discipline. Ms. Smith could not recall if she followed up on the concern voiced by the developmental therapist.

In September 2001, Omega Agency case manager Ms. Smith submitted a Level of Care application for Robert to receive a higher standard of care. Ms. Smith documented on the application that Robert had a history of high risk behaviors including nightly head banging, had irregular eating patterns and irregular bowel movements. The foster mother reported difficulty calming Robert down. Ms. Smith requested Robert be stepped up to specialized foster care. DCFS approved the request in October 2001.

Second DCP Investigation – December 2001 Bite Marks

On December 11, 2001, Ms. Smith received a phone call from a DCP investigator regarding allegations against Ms. Webber for a bite mark on Robert. Ms. Smith told OIG investigators that Ms. Webber felt

⁴ The biological mother of the children Omega Agency placed in her home picked the children up at the foster home for visits.

⁵ Ms. Webber lived 106 miles round trip from the Alpha Agency Office.

⁶ Robert received weekly in-home early intervention services.

⁷ Ms. Smith told OIG investigators she assumed case management responsibilities of Robert Thicke in May 2001. Ms. Smith told OIG investigators that during the first month of the case she had a caseload of approximately 30 children because Omega Agency was short staffed.

irritated by the hotline call and did not understand why no one called her to ask about the bite mark before calling the hotline. Ms. Smith stated that Ms. Webber explained to her that she sometimes played monsters with the children, but never actually bit them. According to Ms. Smith, the DCP investigator told her the bite mark was not consistent with adult teeth. Ms. Smith documented in a case note that DCP unfounded the report because Robert had only one faint bite mark, attributed to another child from daycare.⁸

Early Intervention Services report mistreatment of Robert

On February 1, 2002, Anita's provider for early intervention services called Alpha Agency case manager Monica Gross and reported that Robert was being mistreated.⁹ The case records did not contain any information indicating that Alpha Agency shared this information with Robert's Omega Agency case manager, referred the matter to Alpha Agency's licensing department, or called the hotline. Ms. Gross conducted a home visit four days later, but did not document a discussion with Ms. Webber regarding any concerns about Robert. Anita's early intervention staff reported additional concerns regarding Ms. Webber later that month. The foster parent did not return staff calls or letters and was not home for appointments.¹⁰ Ms. Gross followed up with early intervention concerns in a phone conversation with Ms. Webber on April 8. Ms. Gross requested that Ms. Webber arrange a regular schedule for Anita's developmental therapy. During the home visit Ms. Webber told the case manager that Anita did not like early intervention services and cried the whole time. There was no indication in the case note that Ms. Gross confirmed that Ms. Webber set up a regular schedule for Anita's early intervention services. Problems with Anita's attendance continued through June 2002. Alpha Agency licensing representative Ms. Fredrick told OIG investigators that she knew about the attendance problems but believed the case manager and Ms. Webber worked out a schedule.

Sacha Webber and Kenneth Evans Separate

In June 2002, Alpha Agency case manager Ms. Gross received a phone call from Brianna and Anita's biological mother. Brianna told her mother during a parent child visit that Ms. Webber and Mr. Evans no longer lived together and they lived at the Red Cross. Ms. Webber threatened that if Brianna told anyone, Brianna would not be able to visit her mother and would have to stay in her room. Ms. Gross did not document any follow-up with the foster mother or a visit to determine their place of residence.¹¹ Further, Ms. Gross did not discuss housing in supervision one week later or contact Alpha Agency's licensing division or Omega Agency. Ms. Fredrick told OIG investigators that Ms. Webber told her that Kenneth left sometime in the middle of 2002. Ms. Fredrick stated that Ms. Webber knew the break up would occur and appeared relieved. According to Ms. Fredrick, Ms. Webber's employment after Mr. Evans left included web designing from her home and part-time work at a computer store.¹² Ms. Webber used a neighbor, who was also a licensed foster parent, for childcare.

⁸ The investigation has been expunged from the Child Abuse/Neglect Tracking System.

⁹ The record did not contain specific information regarding how Robert was mistreated.

¹⁰ Over the previous six months Anita's developmental therapist saw her three times; once in her foster home and twice at daycare.

¹¹ Ms. Gross's last documented home visit occurred two weeks earlier. During the visit Ms. Webber reported that she would be moving so she could attend college.

¹² Ms. Webber provided Alpha Agency Licensing with tax returns for 2003 and 2004. Her reported adjusted gross income for 2003 and 2004 was \$11,865 and \$12,465 respectively. However, Ms. Webber documented an annual income of \$29,000 on her foster family home information sheet.

Alpha Agency licensing concerns regarding placement of Vernon Samson

On November 27, 2002, Omega Agency placed eight-year-old Vernon Samson in the home of Sacha Webber.¹³ Jamie Fredrick, the Alpha Agency licensing worker, contacted Omega Agency on December 4 to discuss the placement. Ms. Fredrick informed Omega Agency that Vernon could not remain with Ms. Webber because his needs were too severe. Ms. Fredrick told Omega Agency to look for an alternative placement for Vernon by December 20, 2002. Ms. Fredrick told OIG investigators that while on vacation, her supervisor approved the placement. Ms. Fredrick felt Vernon would be an added pressure, especially since Mr. Evans no longer lived in the home.

Third DCP Investigation- cuts, welts, bruises to Vernon Samson- December 2002

On December 13, 2002, the State Central Register received a report alleging that Vernon Samson had bruising on his left upper arm (SCR # A). Vernon told the reporter that his foster mother, Sacha Webber, grabbed him by the arm, took him to his room and did not let him have any dinner. SCR accepted the hotline call for investigation. During the course of the investigation, Ms. Webber admitted to bruising Vernon’s arm and said this was not the first time she had to use force to get Vernon to go to his room for a time out. The DCP investigator learned that Vernon had a supervision plan that did not allow him to be left alone with other children and that did not allow him to share a bedroom.¹⁴ Webber knew Vernon had some sexual acting out because his brothers “coaxed him,” but did not know about the supervision plan. Ms. Webber told the investigator that she did not leave Vernon alone with other kids for a long time, but he shared a bedroom with Robert.¹⁵

DCP entered a finding of indicated against Ms. Webber for cuts, bruises, welts, abrasions and oral injuries to Vernon Samson. Four and-a-half year-old Robert, two-and-a-half year-old Anita and almost seven year-old Brianna remained in Ms. Webber’s home with her daughters ages three and a half and seven. Omega Agency removed Vernon from the home on January 3, 2003 and placed him in a home where he was the only child.

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Alpha Agency licensing investigation in response to hotline allegations

Jamie Fredrick, Alpha Agency licensing representative, completed a licensing investigation in response to the Sequence A allegations. Ms. Fredrick told OIG investigators that Vernon was larger than the other children and Ms. Webber had a hard time controlling him. Ms. Fredrick stated that the injury was different than a hit or a slap. Ms. Fredrick did not believe Ms. Webber intentionally hurt Vernon; rather the injury occurred when she tried to control him.

Ms. Fredrick interviewed the five verbal children in the home: Vernon, Robert, Kimberly, Maria and Brianna. Robert told Ms. Fredrick that Vernon had to go to his room often and Ms. Webber punched him to make him go. Brianna reported that Vernon told her that Ms. Webber punched him. All of the children, except Vernon, denied being hit by Ms. Webber and reported punishments of time outs and removal of privileges. Ms. Fredrick concluded that Ms. Webber violated Licensing Standard 402.21, Discipline of Children. Ms. Fredrick completed a corrective action plan, monitored the home over the next six months and instructed the Alpha Agency case manger to discuss discipline with Ms. Webber

¹³ Omega Agency previously placed Vernon Samson in Sacha Webber’s home from October 1998 through June 1999 and December 1999 through August 2000, when he was moved to a home of relative placement with his siblings.

¹⁴According to a previous investigation against Vernon’s aunt, her husband sexually abused two of Vernon’s siblings and possibly Vernon. Vernon never received a SACY designation and was considered to be sexually reactive. Vernon’s safety plan included that he would not be left alone unsupervised for sleep arrangements, bathing, playtime or any other time.

¹⁵ Ms. Smith, in a subsequent interview with the DCP investigator, stated she did not give Ms. Webber a copy of the safety plan and never ensured that Vernon had a room of his own.

during monthly home visits. Ms. Fredrick told OIG investigators that she increased phone calls and home visits with Ms. Webber. However, Ms. Fredrick did not discuss the Alpha Agency licensing investigation with Robert's case manager or any Omega Agency staff.

In March 2003, Gamma notified Ms. Gross, Anita's Alpha Agency case manager, that Anita missed seven out of 27 (26%) of her early intervention appointments. Ms. Gross followed up with Ms. Webber who reported that she took Anita to therapy once a week. According to Ms. Webber, the developmental therapist did not show up at the foster home anymore and she did not know why. Ms. Webber told Ms. Gross that she had a hard time getting Anita to her appointments and she did a lot for Anita without getting any help.

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On March 14, 2003, Ms. Webber reported to the Omega Agency worker that Robert had a black eye from falling down the stairs. According to the case record the Omega Agency case manager never visited the home or completed an unusual incident report regarding the black eye. Rather she spoke to four and a half year old Robert on the phone to verify the circumstances of the injury. When Ms. Fredrick (Alpha Agency Licensing) reviewed the corrective action plan for the indicated abuse report one month later (April 21, 2003) she did not know Robert had a black eye and that Anita missed 26% of early intervention appointments.

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Both Ms. Webber and Ms. Fredrick signed the Corrective Action Plan dated May 20, 2003 that documented.¹⁶

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1. Sacha Webber agrees to not use any type of corporal punishment or use of physical force to enforce discipline.
2. Sacha Webber agrees to attend the next training on "Crisis Prevention Intervention." This will be offered by Alpha Agency, the summer of 2003.
3. If Sacha Webber experiences difficulty in enforcing discipline or using effective discipline, she will immediately contact the staff at Alpha Agency. If during office hours she will call the Alpha Agency office. If after hours she will use the emergency pager number to enlist assistance.
4. During monthly caseworker meetings Sacha Webber will discuss all instances of use of discipline during the prior month. Discussion will include effectiveness of discipline and possible alternatives.

Fourth DCP Investigation - Gash on Robert's forehead- June 2003

On June 6, 2003, Robert's daycare staff contacted the Omega Agency case manager, Ms. Smith, to report that Robert had a gash on his forehead. When staff asked Robert how he got the cut he replied "Mama hit me with the big green gun because I wouldn't stay in bed." Ms. Smith called the hotline and SCR accepted the call and opened an investigation (SCR# B). Daycare staff also called the hotline to report the top of Robert's skull was bloodied and he smelled of urine.

Ms. Smith spoke with the DCP investigator and reported that Omega Agency had no suspicion of problems in the home other than the 2002 incident with Vernon Samson (Sequence A) and that Robert regularly banged his head. The DCP investigator and Ms. Smith observed Robert at the daycare that day. During the visit, Robert's teacher reported that Robert was absent "half of the time."¹⁷ The daycare

¹⁶ Ms. Fredrick told OIG investigators that she monitored the corrective action plan on an on-going basis and that it was always "in the back of her mind when she spoke with Ms. Webber." According to Ms. Fredrick, she never formally evaluated the corrective action plan. Ms. Fredrick also reported in her interview with the OIG that she never spoke with Omega Agency about the corrective action plan.

¹⁷ The Preschool, End of the Year Skills form, submitted to Omega Agency as an attachment to the Education Report Form dated May 30, 2003 and signed by Robert's pre-kindergarten teacher indicated that Robert attended 47 out of 98 days.

director reported that she and the teacher “do not see the bipolar or hyper behavior Robert receives meds for; even before the medication was prescribed.” (Omega Agency case record, Case Entry by B. Smith, dated June 6, 2003)

Omega Agency removed Robert from Ms. Webber’s home that afternoon pending the DCP investigation and placed Robert with his brother’s foster parent, Kaycee Sawyer. The other foster children in the home at the time, Brianna and Anita, were not removed, nor was a safety plan developed. Three days later Ms. Sawyer contacted Ms. Smith and reported Robert had not head-banged since being in her home. She also told Ms. Smith that she heard from Ms. Webber’s neighbor that Robert and the other foster children never played outside.

On June 11, 2003, Omega Agency completed a critical decision form that documented Robert would return to the adoptive home of Sacha Webber. That same day, Ms. Smith made a visit to the home and completed a CERAP that indicated the home as safe. Ms. Smith told OIG investigators that Ms. Webber felt frustrated and angry about the DCP investigations. She told Ms. Smith that she was being blamed for Robert’s behaviors. There was no indication that Ms. Smith or DCP ever contacted Alpha Agency at the onset of the DCP investigation. The Alpha Agency foster home licensing representative, Jamie Fredrick, told OIG investigators that she knew about the DCP investigation because Ms. Webber called her. However, Alpha Agency or the Department’s Agency and Institution Licensing did not conduct a licensing investigation or monitoring visit.¹⁸

Ms. Smith documented in a case note (June 16) that Ms. Fredrick (Alpha Agency Licensing Representative) gave permission to place Robert back in the home. Ms. Fredrick told OIG investigators that she did not know that Omega Agency removed Robert during the pending DCP investigation. That same day, Omega Agency obtained a placement waiver from the Placement Clearance Desk to place Robert back in the home of Sacha Webber. Omega Agency documented that they were aware of the previous indicated report (Sequence A, December 2002) against Ms. Webber. However, it remained in Robert’s best interests to return to the home of Ms. Webber. Ms. Smith told OIG investigators that once DCP unfounded the allegations Omega Agency did not have a reason not to return Robert to Ms. Webber.

After DCP closed the sequence B investigation, Ms. Webber left a voice mail message for Ms. Gross and reported that Anita fell and bruised her shoulder and face (Alpha Agency August 2003 case note). Ms. Webber told Ms. Gross she took Anita to the doctor. The Alpha Agency case record did not contain corroboration of a doctor’s visit.

In October 2003 Ms. Fredrick reassessed the Licensed Foster Homes following “Indicated” abuse/neglect findings. Ms. Fredrick documented that Ms. Webber had no other indicated complaints in the last ten months.¹⁹ Further Ms. Webber completed two modules of training on discipline as well as a parenting tape.²⁰ However, Ms. Fredrick’s reassessment of the home did not include consideration of the June 2003 hotline call or the addition of Ms. Webber’s one-year-old niece, Erica, two months earlier.

¹⁸ According to Procedures 383, Licensing Enforcement, responsibility of concurrent licensing investigations became the responsibility of DCFS Agency and Institution Licensing effective January 1, 2003. See page 23 of this report for further discussion.

¹⁹ The reassessment does not ask for information regarding unfounded reports.

²⁰ The parenting tape advocates locking difficult children in their rooms (as a form of time-out), a violation of licensing standards. In the 1990 video product, a home day care provider is portrayed as advocating for the methods, an ethically questionable marketing strategy since it is a violation of day care licensing. In an early OIG death investigation a foster parent locked a child in a kitchen cabinet justifying her “aggressive” method of controlling the child as part of her parenting videotape training.

SCR Referral to Alpha Agency Licensing Department- December 2003

On December 29, 2003 SCR received an anonymous report alleging that Anita slept with her foster parent and stated, "I go potty and I don't get my butt spanked." SCR staff referred the matter to Alpha Agency's licensing department for investigation. Ms. Fredrick conducted a licensing investigation and made a visit to the foster home on January 3, 2004. Ms. Fredrick documented that she viewed the entire house and talked to both the foster mother and the children about discipline. Ms. Fredrick completed her licensing investigation on January 16, 2004 and found no violations in the foster home. She noted that during all of her interviews the children denied corporal punishment. Alpha Agency speculated that the complaint might have come from the biological mother in retaliation for a previous hotline call made by Ms. Webber.²¹ Ms. Fredrick told OIG investigators that she discussed toileting issues with Ms. Webber and suggested different books as resources. Ms. Webber appeared open to her interventions. Ms. Smith told OIG investigators that she believed Ms. Webber spanked the children, but never knew about allegations of Ms. Webber sharing a bed with a foster child.

Several days earlier, SCR had taken a report involving Ms. Webber as information only when an anonymous reporter stated Anita had a black eye from falling down the stairs.

Anita's Preschool voices concerns

On January 5, 2004, the nurse from Anita's preschool contacted Ms. Gross because Anita appeared shaky and fell down. Anita drank five cups of water and juice, and had four helpings of the snack. The nurse told Ms. Gross she did not know how much she trusted Ms. Webber. Anita was often late for school, she did not ride the bus as outlined in her IEP, and the children got spanked. Anita's speech was difficult to understand and she worried Anita could not communicate. The nurse planned to call the DCFS hotline.²² Later that month Anita saw her primary care physician regarding her frequent urination. Anita tested negative for diabetes and the doctor requested school staff be informed Anita should not be taken to the bathroom as often as she requested.

Fifth DCP Investigation - Mistreatment of Robert- January 2004

On January 23, 2004, Omega Agency case manager Ms. Smith made a hotline call and reported that she received phone calls from another foster parent, Robert's teacher and other members of the community who expressed concern about Ms. Webber's treatment of Robert. Robert told people that Ms. Webber spanked him with a paddle, pushed him down the stairs and did not feed him. Ms. Smith told the hotline operator that she had serious concerns about Robert's care in this home and had attempted a home visit, but no one was home. The Division of Child Protection opened an investigation (sequence C). Ms. Smith told OIG investigators that she did not believe that Ms. Webber starved Robert. She knew that Robert's food intake had to be monitored because he would eat until he became ill. During a parent child visit Robert ate so many tacos he threw up. Ms. Smith discussed Robert's appetite with his doctor. Robert had a high metabolism and his body's slow absorption of nutrients could have been associated with food cravings. Ms. Smith told OIG investigators that when she discussed the allegations with Robert, he often replied that he did not know the answers to her questions. Ms. Smith said she looked for a white paddle in the foster home, but never found one.

During the open investigation, the DCP investigator completed a protective plan with Ms. Webber, signed by both parties on January 25, 2004, that read:

²¹ Ms. Webber made a hotline call against the biological mother after Anita and Brianna returned from a visit with bruises.

²² SCR accepted this call as information only and indicated the information would be sent as a licensing referral. However, Alpha Agency licensing records did not contain a referral for a licensing investigation.

I, Sacha Webber, agree to continue to not use any physical discipline on the children in my care. I also agree to continue to comply with licensing expectations for all the children in my care.

In a case note dated January 26, 2004 Ms. Gross documented a phone call from Ms. Webber who inquired if the case manager knew about the recent DCP investigation. Ms. Webber felt the school called the hotline because she requested extra services for Anita. There was no indication that Ms. Gross attempted to find out more information about the allegations against Ms. Webber. Also, there was no indication that Ms. Gross discussed the incident with her supervisor, Alpha Agency licensing, or Omega Agency.

That same day the DCP investigator contacted Alpha Agency supervisor Jill Durham about the Sequence C investigation. The DCP investigator reported the allegations against Ms. Webber included that she did not feed Robert, pushed Robert down the stairs and paddled him. The DCP investigator reported that Robert denied all allegations. Robert had no marks or other indications of being paddled. The home appeared to have adequate food. DCP later entered a finding of unfounded for allegations of inadequate food and substantial risk of physical injury/ environment injurious to health and welfare of a child against Ms. Webber to Robert. At a home visit on January 30, Ms. Webber told Ms. Gross that she considered filing harassment charges against the biological mother for making hotline calls against her.²³

Licensing Referral -- March 2004

On March 23, 2004 the SCR received a call from Ms. Webber's landlord because the gas company turned off the gas at Ms. Webber's home. SCR took the information as a licensing referral. However, the Alpha Agency licensing record did not contain any information about the call or further investigation by Alpha Agency licensing staff.

Sixth DCP Investigation - Discipline of foster children- July 2004

On July 9, 2004 SCR received an anonymous complaint that Sacha Webber disciplined the foster children in her home by making them stand in a corner with a dirty sock in their mouth and making them keep their hands in the air for approximately 10-15 minutes. The foster mother also zipped Robert in a tent at night so he could not leave his room. The reporter alleged that Ms. Webber abused her foster children more than her biological children and spanked Robert, a special needs foster child. The hotline accepted the call and opened an investigation (Sequence D) for allegations of torture, tying/confinement and substantial risk of physical injury.

The assigned CPSW made an in-person visit to Ms. Webber home on July 10, 2004. Ms. Webber explained that Robert's bed had a cover because Robert head banged. Ms. Webber stated that the licensing worker, caseworker and doctor knew about the bed. Ms. Webber told the CPSW that she thought the report probably came from her ex-husband or his family because of the custody battle for their two children. Ms. Webber stated the children stood in the corner for a short period of time with their hands at their sides, but denied spanking the children or putting anything in their mouth. During the visit, the CPSW observed a cover on Robert's bed, which had a large enough opening for a child to get out.²⁴ The CPSW spoke with Brianna (8), Robert (5), Maria (9) and Kimberly (4). All four children corroborated that they stood in the corner for discipline and denied being hurt, scared of anyone in the home or having anything put in their mouths. Sometimes Ms. Webber sent them to their rooms for discipline. The CPSW observed Erica (2) and Anita (3) who appeared free from indications of abuse or neglect.

²³ Review of the DCP investigations revealed that of the seven hotline calls (sequences A-G) an anonymous caller made one. Mandated reporters made the other six calls.

²⁴ At a subsequent visit, the CPSW observed Robert climb in and out of the bed without assistance. The case record did not contain a clear description of the cover for Robert's bed.

Regarding Robert, the CPSW spoke with Ms. Smith and Dr. Tower's office, the pediatric neurologist. Both corroborated the use of the bed to discourage Robert from head banging. The caseworker said she never observed any suspicious marks on Robert and did not feel that the foster parent hurt Robert. The nurse from Robert's pediatric neurologist's office stated that Robert did bang his head periodically. Dr Tower had last seen Robert in May 2004.

The CPSW also spoke with Ms. Fredrick, Alpha Agency licensing worker for the Webber home. Ms. Fredrick told the investigator, "Ms. Webber probably does discipline the foster children more frequently than she does her own children." Ms. Fredrick told the investigator she previously discussed appropriate limits for the time-outs with Ms. Webber.

On July 12, 2004 during a phone conversation, Ms. Webber told Ms. Smith that someone called the hotline and alleged she abused her biological and foster children. Ms. Webber felt that Mr. Evans' family made the call because of their custody battle. Ms. Webber followed up with Ms. Smith one week later and reported DCP entered a determination of unfounded for the allegations against her. Approximately one month later, Ms. Smith left her position with the Omega Agency Office. According to Ms. Smith, her concern about Robert grew during the end of her case management of the case. She felt something was going on, possibly that Ms. Webber was too rough with Robert. However, she appeared to be meeting his needs and her explanations always seemed plausible. Ms. Smith did not recall completing a written transfer summary about the case, but did update the social history prior to leaving. Ms. Smith's concerns were not documented in the case record.

The Division of Child Protection did not substantiate the allegations against Ms. Webber and closed the Sequence D investigation as unfounded on September 1, 2004.

Seventh DCP Investigation - cuts, welts, bruises to Robert- September 2004

On September 2, 2004, the day after DCP closed the sequence D investigation as unfounded, the hotline received a phone call from the school regarding Robert. The school nurse noted that Robert came to the nurse's office because of a bee sting. The nurse observed bilateral bruising on both sides of his neck, bruising on both ears, and an index finger print on one side of his neck. Ms. Webber told the school that a bee stung Robert two weeks ago and caused the bruising. The school nurse told the hotline operator that the bruising did not appear consistent with a bee sting and the school made previous hotline calls for bruising to Robert. The hotline accepted the call and opened an investigation for allegations of cuts/welt/bruises to Robert (Sequence E). The hotline received a related information call regarding Robert. According to the reporter, Robert came to school and told his teacher that Ms. Webber kicked him on his butt that morning. Robert had numerous unexcused absences from school and Robert cringed when adults lifted their arms around him.

The assigned CPSW interviewed Robert at school the same day as the hotline call. Robert explained the bruising on his neck as resulting from a bee sting on his ear that made him swell up. The bee sting happened while he was riding in the car on the way to his grandmother's house. Robert denied that anyone ever grabbed him by the neck. Robert reported that when he got in trouble he had to stand in the corner or go to his room.

The CPSW interviewed Brianna also at school, who corroborated that a bee stung Robert on the way to Wisconsin. Brianna told the CPSW that about a week ago Robert was red and swollen then he got bruises. Brianna denied ever being spanked.

According to Ms. Webber, the first bee sting took place two Saturdays ago (*approximately August 21, 2004*). Ms. Webber explained that on the way to Wisconsin Robert complained that he had a headache

and started crying. When they arrived in Wisconsin, she removed Robert's baseball cap and observed the back of his head to be swollen and red with some bruising. She gave Robert Benadryl. According to Ms. Webber, the marks in the allegations against her were the same as the swelling from the bee sting. When Robert got stung a second time on September 2, Ms. Webber took Robert to Dr. Harper.²⁵ Ms. Webber asked the doctor why he did not swell as much this time. The doctor explained that because Robert already had Benadryl, the effects of the sting could have been less. The doctor prescribed an epi-pen. Ms. Webber told the CPSW that she told Omega Agency about the bee sting in Wisconsin. The Omega Agency case record did not contain documentation of a conversation between staff and Ms. Webber regarding the bee sting. The CPSW interviewed the other children in the home regarding the incident. Kimberly (5) stated that a bee stung Robert while on the way to Wisconsin. When they got in the car his neck wasn't red, but when they got out it was red and swollen. Anita (4) did not know what happened to Robert.

The CPSW spoke with a nurse at Dr. Harper's office. Robert came into the office on September 2 for a bee sting on his leg. The nurse told the investigator they did not have concerns regarding abuse or neglect for Robert.²⁶ The CPSW also spoke with Ms. Webber's mother who corroborated that a bee stung Robert.

On October 14, the DCP investigator contacted Marcus Ford, Robert's Omega Agency case manager. According to the investigative note, Mr. Ford started with Omega Agency two weeks prior. The DCP investigator advised him of the report and the allegations appeared unsubstantiated. The DCP investigator planned to close the case as soon as the doctor provided documentation of Robert's visit. Four days later, on October 18, 2004, DCP unfounded the allegations against Ms. Webber and closed the investigation.

Eighth DCP Investigation -cuts, welts, bruises to Robert- February 2005

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On February 15, 2005 the SCR received a hotline call from Robert's school alleging that Ms. Webber abused Robert (Sequence F). Robert told the reporter that Ms. Webber threw food at him that caused a bruise on his forehead. Robert also told the reporter that he did not have any breakfast that morning. The reporter told the SCR operator that the physical abuse by Ms. Webber and Robert not getting fed occurred regularly. The hotline accepted the call and DCP opened an investigation for allegations of cuts/bruises/welts.

The CPSW interviewed Robert at school. Robert told the reporter he ate breakfast with the principal this morning. The CPSW noted that during the interview Robert asked the school secretary and the investigator if he could have a snack. The CPSW noted in the contact note that Robert had two minor bruises on the right side of his forehead. Robert explained the bruises on his head by "I banged it...my bed." Robert denied that Ms. Webber spanked or hit him. The CPSW also interviewed Maria, Kimberly and Brianna at the school. Maria told the CPSW that Robert head banged last night. Kimberly told the CPSW that she knew Robert had a bruise but didn't know how he got it. Brianna did not know about Robert's bruises, but told the CPSW that Robert head bangs. All three girls denied not getting enough food.

The CPSW also interviewed the school principal who stated that Robert flinched when discussing Ms. Webber and Ms. Webber "can be very surly." The principal stated that when the school gave Robert breakfast this morning he ate like he was starving and he always finished his lunch. The principal stated that Robert had a voracious appetite for a child his age and size. Ms. Webber argued with staff about

²⁵ Dr. Harper is a pediatrician. Robert's primary care physician, Dr. Walls is also a pediatrician in the same practice.

²⁶ According to Dr. Harper's notes, Robert had some bruising on the neck with some yellowish discoloration. The doctor did not observe any swelling of the neck.

them feeding Robert at school. Robert has missed approximately 15 days, which bordered on truancy. Other school staff also expressed concern about Robert's school attendance and because of the issue the school required that Ms. Webber provide a doctor's excuse if Robert did not attend school.

The CPSW made a visit to the home and observed it to be safe and appropriate. Ms. Webber explained that Robert bruised himself while head banging. Robert had a diagnosis of Reactive Attachment Disorder and tended to do or say things to get attention. Ms. Webber told the CPSW that Robert had no regulatory system and that he ate until ill so she had to limit his eating.

The day of the hotline report, February 15, 2005, Ms. Webber called Mr. Ford, Robert's case manager, to report DCP interviewed the children at school today. Robert went to school with a bruise on his forehead from banging his head. Ms. Webber requested that Omega Agency arrange a meeting with the school to discuss Robert. If this continued to happen (hotline calls) she would have to let Robert go because it caused problems with her family.

The CPSW made several collateral contacts. Robert saw Dr. Walls on February 21, 2005 for the bruise on his forehead. According to the doctor, Ms. Webber was very disciplined and her children were disciplined and well behaved. The doctor told the CPSW that Robert was healthy and did not have any signs of malnutrition. Dr. Walls first saw Robert in September 2003.²⁷ Mr. Ford told the CPSW that Ms. Webber did not deprive Robert of food, they had no concerns and Ms. Webber appeared to be a strong foster mother.

During the open Sequence F investigation, Mr. Ford conducted a home visit. Ms. Webber told Mr. Ford that on Saturday Robert pulled his pants down and went to the bathroom in his bed. Reportedly, Robert also wet his pants at school and the school did not tell the foster mother. During his interview with the OIG, Mr. Ford stated that Ms. Webber became very upset about the toileting accident at school. Also during the Sequence F investigation Robert returned to the nurse practitioner (March 7, 2005) accompanied by Ms. Webber. The nurse practitioner and Ms. Webber discussed the Center report.²⁸ Robert would see an endocrinologist for his short stature; have lab studies to evaluate high-density chromosomes and karyotype and an MRI of the brain.

Ms. Walker also visited the home (February 18) during the open Sequence F investigation and documented that the girls appeared fine, but Brianna had not started counseling yet. Ms. Walker instructed the foster parent to contact Ann Brown at Alpha Agency to arrange counseling. The case note completed by Ms. Walker did not indicate that she discussed the pending allegations against Ms. Webber. Ms. Walker told OIG investigators she had no knowledge of the Sequence F investigation.

On March 16, 2005 DCP unfounded the allegations against Ms. Webber and closed the investigation.

Ninth DCP Investigation – August 2005

On August 7, 2005 the State Central Register received a hotline call from the County Sheriff's Department that an officer responded to a complaint that Sacha Webber fought with her foster children. When the sheriff's department arrived at the home they found seven-year-old Robert urine soaked in his bedroom with a plastic bucket of Lysol disinfectant. Robert did not have a bed and Brianna had scratches on her arm. The reporter felt the children were not in a safe environment. The hotline received a second phone call from an anonymous reporter stating they witnessed Robert sleeping on a bare floor with no

²⁷ According to DPA records, Robert saw Dr. Walls beginning in September 2003.

²⁸ Robert had a psychological and medical evaluation at the Children's Mental Health Center in August 2004.

covers because he wet the bed. The foster mother also made Robert stay in his room for hours and recently struck Robert with a board that caused bruises on his buttocks and legs.²⁹

DCP opened an investigation (Sequence G) on Sacha Webber for allegations of inadequate supervision, environmental neglect, cuts/bruises/welts, and substantial risk of physical injury and assigned CPSW Antoine Nealy to meet the 24-hour mandate.³⁰ Mr. Nealy called Ms. Webber en route to the home at approximately 11:55 p.m. on August 7 to advise her that the children needed to be seen tonight. Ms. Webber told Mr. Nealy that she and the children³¹ were in the van traveling to Wisconsin to stay with her mother. Ms. Webber stated the events of the day stressed her out, Brianna threw a three hour temper tantrum and Robert peed all over his room. Ms. Webber said she threw away his mattress because it was urine soaked. Ms. Webber assured Mr. Nealy that the children were fine now and someone probably called the sheriff's department because they heard Brianna throwing a tantrum. CPSW Nealy asked Ms. Webber to call him in the morning so an arrangement could be made to see the children.

The following day CPSW Constance Young took over the Sequence G investigation and received supervision from Ashley Sailor. CPSW Young left messages for the Omega Agency worker and the Alpha Agency worker to alert them of the hotline call.

Ms. Sailor contacted the neighboring state's Department of Human Services (DHS) and requested a welfare check for the children in Ms. Webber's care and provided the phone number and address of the maternal grandmother's home. That afternoon the DHS worker contacted Ms. Sailor and reported that there was no one home and no cars in the driveway at the address. A neighbor approached the DHS worker and stated that Ms. Webber's mother has been in Kentucky for a week and Ms. Webber had not been there. According to the neighbor, he would have called the police if Ms. Webber came to the home because she was mean and did not get along with her family. The neighbor agreed to call the DHS worker if Ms. Webber showed up. CPSW Supervisor Sailor contacted the Sheriff's Department and requested a check of Ms. Webber home for the children. Again, no one was home. The Sheriff's Department planned to have squads periodically check the home and if they found Ms. Webber they would stand by until DCFS arrived.

Marcus Ford, Omega Agency caseworker for Robert, contacted Ms. Young and stated that he attempted a visit at the Webber foster home that morning (August 8) and no one answered the door, he saw no cars in the driveway and Ms. Webber did not answer her cell phone or return any of his calls.

DCP Supervisor Sailor spoke with Alpha Agency licensing staff who stated that Ms. Webber did not have permission to take the children out of state. The Alpha Agency worker gave Ms. Sailor Ms. Webber's license plate number, social security number, and date of birth along with names and phone numbers of family Ms. Webber may visit.

After multiple attempts by the private agencies and DCP staff, Ms. Webber agreed to bring her foster children to the DCFS Field Office by 6:30 pm on August 8, 2005. Ms. Webber told the CPSW Supervisor that she panicked when the sheriff's department came to her door, and left with the children. When Ms. Webber arrived at the DCFS Field Office, DCP removed all three foster children from her care. Ms. Webber also agreed that her biological children could stay with their father and her niece could stay with a friend until further notice from DCFS.

²⁹ The allegations from the Sequence C investigation in January 2004 included Ms. Webber hitting Robert with a paddle.

³⁰ CPSW Nealy also investigated the Sequence F investigation.

³¹ Biological children Maria (10) and Kimberly (5), niece Erica (3); Foster Children: Brianna (9), Anita (4) and Robert (7).

The following day, Robert had a medical examination that revealed peeling skin on his back and face, healing contusions on both buttocks and posterior thighs bilaterally. The physician opined that the contusions appeared consistent with a belt. The physician also noted circular lesions on the dorsal surface of Robert's feet that appeared scabbed and consistent with burns. The physician noted similar lesions on the second, third and fourth digits of Robert's right hand.

On August 9, CPSW Young interviewed the biological father of Kimberly and Maria, Kenneth Evans. Mr. Evans reported that he had the girls every other week in the summer. Mr. Evans reported that he did not question the girls about their life with Ms. Webber because everything was a secret. The girls told Mr. Evans that Robert pooped his pants and hid it so he did not get in trouble. Both girls stated that Ms. Webber spanked Robert. Maria told her father that in the past Ms. Webber left her to care for the children by herself. Mr. Evans also expressed concern that Ms. Webber tried to diagnosis the children without taking them to the doctor and in the past Ms. Webber "flipped out" without any warning.

The following day, CPSW Young interviewed Ms. Webber with a County Deputy. Ms. Webber admitted that on Saturday she spanked Robert with a decorative paddle. Ms. Webber stated that on a scale from one to ten she spanked Robert at a 7-8. Ms. Webber admitted that she threw the paddle she used to spank Robert into the river. Ms. Webber reported that Robert pooped and peed all over the house so she spanked him because nothing else worked. The following day Robert had bruises on his buttocks. Ms. Webber denied causing any injuries to Brianna.

Later on August 10, CPSW Young interviewed Ms. Webber's neighbor who stated that he called Omega Agency last year and complained that Ms. Webber swore at and mistreated the children. The neighbor heard Ms. Webber yell at the children one to two times a week, most recently last Sunday. The neighbor also reported that Ms. Webber's biological children played outside all summer, but the other children had been inside all summer.³²

CPSW Young observed Sacha Webber's home on August 18, 2005. During the tour of the home, the CPSW observed a strong urine odor in Robert's room. Further, Robert's room had no bed, just a baby corral and a wadded up rag on the tile floor. In the garage the CPSW observed a plastic car bed in pieces. Ms. Webber explained the brown substance on the bed to be feces. During the DCP investigation, Ms. Webber participated in a mental health assessment through Alpha Agency. The examiner found that Ms. Webber was isolated with no support system. Ms. Webber agreed to participate in therapy, anger management and parenting classes.

The County Sheriff's Office arrested Sacha Webber on August 19. She was convicted of domestic battery/bodily harm and sentenced to 18 months probation.

The Division of Child Protection closed the investigation on October 7, 2005 with a determination of indicated against Sacha Webber for environmental neglect (82) to Robert, cuts, bruises, welts, abrasions and oral injuries (11) to Robert and substantial risk of physical injury/environment injurious to health and welfare by neglect (60) to Robert, Brianna, Anita, Kimberly, Maria, and Erica.

³² In the Sequence B investigation in June 2003 Mrs. Sawyer made the same complaint to the Omega Agency case manager about the foster children never playing outside.

Omega Agency Monitoring of the Sacha Webber foster home

Omega Agency placed 15 month-old Robert Thicke in the home of Sacha Webber on October 21, 1999.³³ At the time of his placement, Ms. Webber cared for three other foster children ages six, seven, and eight in addition to her one-year-old and three-year-old daughters.³⁴ While Robert lived with Ms. Webber he had multiple special needs that required medical, developmental and educational services. The Omega Agency case manager noted that Ms. Webber reported that Robert banged his head and was always thirsty (June 15, 2000 Omega Agency case note). Within the first year of his placement, Robert's primary care physician, Dr. Walton, noted concern about Robert's small stature and planned to assess him for failure to thrive (June 2000). Robert required regular appointments with a gastroenterologist to address loose stool and lack of weight gain despite a very good appetite. According to Ms. Webber, Robert ate until he became ill if she did not monitor his food intake. Robert measured in the fifth percentile for height and the 25th percentile for weight. Robert was diagnosed Failure to Thrive, diarrhea and hypoproteinemia.³⁵ Over the next three and a half years, Robert saw a gastroenterologist for chronic constipation with overflow diarrhea and took MiraLax, Milk of Magnesia, prune and apricot juice and enemas to manage his constipation. In July 2000 at the age of two, Robert began early intervention services for weekly speech, developmental and occupational therapy for one hour each. Robert also attended a weekly playgroup.

Psychological exam of Robert – February 2001

Robert's early intervention therapists, who began seeing Robert in July 2000 for weekly speech, developmental and occupational therapy, recommended a psychological assessment and neurological evaluation. Two-and-a-half year-old Robert participated in a psychological evaluation in February 2001. Ms. Webber reported to the examiner that Robert had quick and frequent switches in his mood, banged his head against the floor or wall when angry or trying to sleep, ate constantly, slept little, had difficulty sharing, and became angry for long periods of time. The examiner wrote "Robert may be experiencing some early signs of a biochemical imbalance and/or early evidence of an Attention Deficit Hyperactivity Disorder, or as an example, a bi-polar personality disorder." The examiner recommended a neurological evaluation, possible medication treatment, and an assessment through the school district for early childhood development.

One month later Robert attended his first appointment with a pediatric neurologist, Dr. Sellers. During the assessment, Ms. Webber reported that Robert appeared hyper and slept two hours a night with head banging. Dr. Sellers prescribed Robert .01mg of Clonidine to be taken at bedtime. If the sleep

³³ Robert had one previous foster placement for eight months that disrupted when his traditional foster parent could no longer care for him because of medical reasons.

³⁴ During the duration of Robert's nearly five-year placement with Ms. Webber, Omega Agency case managers documented only 11 visits to Robert in the foster home. The longest period without a documented home visit took place from August 2000 through February 2002, 19 months. Kelly Smith, who managed the case from February 2001 until August 2004 told OIG investigators she saw Robert in the home at least twice a month. Some months she saw Robert more because she transported him to visits with his siblings and parents. However, Ms. Smith stated she did not always document home visits in case notes because of her workload. Ms. Smith's supervisor did not regularly review her case notes, but spoke to her about the need to complete the required documentation. At one point a supervisor recommended that Ms. Smith come in two hours early to complete case notes. According to Ms. Smith, her supervisor never noted a lack of case notes in any of her annual evaluations. Ms. Smith told OIG investigators that completing case notes was a problem within the office.

³⁵ Robert's medical records did not specify organic or in-organic failure to thrive. Hypoproteinemia is abnormally low levels of protein in the blood.

disturbances continued Ms. Webber could increase the dosage to ½ tablet as needed. Ms. Webber filled Robert's first prescription for Clonidine on May 29, 2001.³⁶

Robert's school progress

When Robert turned three he received a special education assessment (June 2001), but did not meet the criteria for special education services. When Ms. Webber worked or attended school, Robert went to several different pre-school programs. Ms. Webber used a neighbor, a foster parent, for childcare.

In the fall of 2003 Robert's school recommended a full day (preschool supplemented by afternoons in the kindergarten classroom) because of his behavior issues and a maturity level below his peers.

By April 2004, Robert attended kindergarten full time with the use of a behavior modification plan. Robert's teachers described him as intelligent, verbal and outgoing. However, Robert continued to be easily distracted in the classroom. In September 2004 Robert would attend regular education classes in the first grade with a behavior plan. Ms. Smith told OIG investigators that Ms. Webber did not have a good relationship with school staff because Ms. Webber believed the school made hotline reports on her and the school did not follow her request to limit Robert's sugar intake.³⁷ Ms. Webber told Ms. Smith that the school took Robert's side and she felt victimized. According to Ms. Smith, Ms. Webber planned to transfer Robert to a private school once she adopted him.

Robert's Evaluation at Children's Mental Health Center – August 2004

In August 2004, Robert attended an evaluation through Children's Mental Health Center.³⁸ Kelly Smith with Omega Agency referred Robert for the evaluation at the request of Sacha Webber.³⁹ The Omega Agency case record did not contain documentation of any historical information that Ms. Smith provided to Children's Mental Health Center.⁴⁰ Ms. Webber reported to the examiners that Robert displayed emotional and self-destructive behavior. Robert continued to bang his head and had tantrums. He slept as little as four hours nightly and she removed all hard surfaces from his room. Robert attempted to get her attention by threatening to hurt himself, but never carried through. Robert also threatened to wet his pants on days he did not want to attend school. Ms. Webber described Robert as manipulative, anxious and fearful. Further Robert had an insatiable appetite and ate to the point of vomiting if not regulated. The recommendations included:

- Attachment-Trauma Focused Therapy
- Evaluation by an occupational therapist trained in Sensory Integration

³⁶ From May 2001 through January 2002, Ms. Webber refilled Robert's Clonidine on a monthly basis. However, after January 2002, Ms. Webber inconsistently refilled the prescriptions. For further discussion of Robert's psychotropic medication regime *see* page 18 of this Report.

³⁷ Ms. Webber contacted Robert's pediatric neurologist in March and requested a letter for the school that would limit Robert's sugar intake because the school gave him too many sugary snacks.

³⁸ According to The Department's contract with the Children's Mental Health Center for fiscal year 2005 psychological testing includes six assessment axes designated by the source of information about the child: parent reports, cognitive assessment, physical assessment, direct assessment of the child, family environment, and school environment (Achenback, 1991a; McConaughty, 1993) The family assessment focuses on the foster family. The Assessment model procedure for the Family Environment Assessment included Parenting Stress Index.

³⁹ Ms. Smith left the Field Office prior to Robert's evaluation at Children's Mental Health Center. Robert's case was temporarily assigned to a supervisor Shelly Goodwin who no longer works for Omega Agency.

⁴⁰ According to the Department's contract with Children's Mental Health Center contact with the DCFS caseworker is imperative to the quality services of care we provide to make sure that the services provided for in the Recommendation Section of the Treatment Plan/Report are being provided. CRT case management provides ongoing communication with the caseworker as long as the child is receiving evaluation and treatment services at CRT. CRT also offers consultation services to the foster parent to evaluate progress of the child.

- Endocrine evaluation for his short stature
- MRI of the brain and karyotype to evaluate for Microcephaly
- Continue with Pediatric Neurology Services
- Continue with Pediatric GI Services as needed.

Omega Agency contracted with a specialist, approximately 102 miles from the foster home, to provide Robert with the recommended Attachment-Trauma focused therapy from January 17, 2005 through June 30, 2005 for 24 sessions. However, Ms. Webber never took Robert to the recommended therapy. According to Mr. Ford (Omega Agency case manager) and Ms. Thomas (Omega Agency supervisor), Ms. Webber needed to participate in the therapy with Robert, so her cooperation was crucial. Further, Omega Agency did not have a resource for the therapy closer to the foster home. During an interview with OIG staff, Ms. Thomas stated that in July 2005 Omega Agency realized that Ms. Webber never took Robert for therapy because no money had been used out of the contract for Robert's therapy.

In October 2004 Marcus Ford with Omega Agency conducted his first home visit with Robert and Ms. Webber. According to CYCIS, he assumed case management responsibilities of Robert's case in December 2004. Mr. Ford returned to the home in February 2005. During the visit, Ms. Webber told Mr. Ford that Robert had not peed in his room for the last week. During an interview with OIG investigators, Mr. Ford stated that Robert began urinating in his room in December 2004.⁴¹ According to Mr. Ford, Robert urinated both in his bed and on the floor. Mr. Ford described Robert's room as having a strong urine odor. Ms. Webber removed all furniture from Robert's room to discourage head banging and the floor had linoleum. Mr. Ford told OIG investigators that Ms. Webber made Robert clean up the urine in his room as a form of punishment. Mr. Ford stated that at that time, he did not consider the punishment as inappropriate.

Robert's Individualized Education Plan March 2005

On March 11, 2005, Omega Agency and Ms. Webber met with school staff for a preliminary meeting regarding Robert's upcoming IEP. The school principal felt Robert made tremendous improvement. The school expressed concern that Robert missed 19 days as of March 1, 2005. During the meeting Ms. Webber described physical and emotional issues including eating and detachment disorders for Robert. Ms. Webber expressed a desire to home school Robert next fall in order to form a better attachment. Mr. Taylor, school principal, documented:

It should be noted that Robert is very warm and affectionate; he has eye contact; is never cruel; answers questions; is not involved with anger within or around him; is not emotional; accepts discipline; has exceptional learning; is usually focused and on task; is not overly clingy, and is honest. Therefore we are doubtful about the extent of the RAD diagnosis. The school portion of the team were opposed to him being taken out of school because of his successful academic year, and especially because of strides that he has made in regard to social development with his first grade peers.

Mr. Ford told OIG investigators that Omega Agency relied on the Children's Mental Health Center assessment to guide Robert's services because the professional conducting the assessments had the expertise. Further Mr. Ford told OIG investigators that Ms. Webber had a lot of confrontations with school staff and became upset when school staff fed Robert when she requested no snacks. According to Mr. Ford, Robert did not stop eating until he became ill so his eating had to be monitored. Ms. Webber also did not allow Robert to have soda or sweets because she said they made him hyper. Mr. Ford never discussed any dietary restrictions with any of Robert's physicians. Mr. Ford attributed Robert's absences to his many doctor appointments.

⁴¹ Ms. Smith told OIG staff she did not remember Robert having a problem with urination while she had the case.

On April 5 Ms. Webber called Mr. Ford and reported that Robert continued to wet his pants and did not know if Robert had a GI problem or if it was behavioral. Robert had three appointments coming up; April 8 for Reactive Attachment disorder, April 18 with the neurologist to discuss his MRI, and April 21 to see an urologist.

Mr. Ford returned to the foster home on June 24 for a visit. Ms. Webber reported that Robert's behavior improved. However, he still urinated in his pants. Ms. Webber grounded Robert from TV for swearing. During his interview with the OIG, Mr. Ford reported that Robert "always seemed to be in trouble for something he did whether in the home or at school."

Mr. Ford made another visit to the home on July 7, 2005. Robert told Mr. Ford that he enjoyed the fourth of July and liked summer vacation. The foster mother reported Robert continued to urinate in his room. Mr. Ford asked Robert why, but Robert did not know. Mr. Ford asked Robert if he liked his room to smell like urine, and Robert replied no (Omega Agency Foster Parents Visits form dated July 7, 2005). This contact was the last Mr. Ford had with the family until Robert was removed from the home on August 12, 2005.

Monitoring of Robert's Psychotropic Medications

OIG review of Robert's pediatric neurologist records show regular prescriptions for psychotropic medications to address his diagnosis of ADHD and sleep disturbances beginning shortly before his third birthday. However, review of the Illinois Department of Public Aid Claim Recipient details for Robert revealed that Ms. Webber did not consistently refill Robert's medications as prescribed (See Appendix Two attached to this report).

After Robert's initial pediatric neurology assessment he attended two subsequent appointments with Dr. Sellers on July 15, 2001, and September 26, 2001. During each visit, Ms. Webber reported that Robert continued to have difficulty sleeping through the night. At the September visit, Dr. Sellers added 5 mgs Adderall to be taken every morning. Ms. Webber routinely refilled Robert's prescriptions for Clonidine between July 2001 and January 2002. Ms. Smith told OIG investigators that she believed Ms. Webber followed Robert's medication regime, but did not verify this by asking Ms. Webber, observing medication bottles or reviewing medication logs.

In March 2002, Robert transferred to a new pediatric neurologist, Dr. Tower.⁴² During Robert's first visit with Dr. Tower, Ms. Webber reported Robert slept two hours a night, displayed physical aggression, rapid speech, and difficulty staying on task. The doctor prescribed Robert Klonopin .5mg at bedtime. Robert's diagnosis included ADHD with a Rule Out of Bi-Polar Disorder. DCFS approved the request for Klonopin for two weeks only and requested the consideration of an alternative medication. The doctor switched Robert back to Clonidine. Robert returned to his pediatric neurologist in June 2002. Ms. Webber reported that Robert did much better with the Adderall. She gave him the Clonidine in the evening with an additional pill at four o'clock in the morning when necessary. The pediatric neurologist noted that Robert appeared intellectually advanced for his age. He sat quietly on the examining table and all reflexes appeared normal.

When Ms. Webber took Robert back to his neurologist on November 4, 2003 she told Dr. Tower that Robert did poorly and got "kicked out of kindergarten" for his behavior. According to Ms. Webber, she

⁴² In January 2002, Ms. Webber told Robert's case manager that Dr. Sellers planned to move and they needed a new pediatric neurologist.

noticed no improvement with the Adderall and the Clonidine.⁴³ Dr. Tower increased the Adderall dosage to 15 mg and replaced the Clonidine with Remeron. The doctor requested Robert return in three to four weeks for reevaluation.⁴⁴ At the end of April Ms. Webber called the pediatric neurologist and reported the Remeron did not work, the doctor switched Robert back to Clonidine.

Robert saw a nurse practitioner at the end of May 2004 and Ms. Webber reported that Robert would have an evaluation at the Children's Mental Health Center and she believed he had an attachment disorder. Ms. Webber reported that the Adderall helped Robert's behavior and the Clonidine helped his sleep. However, IDPA records indicate that Ms. Webber had not filled Robert's prescriptions for Adderall and Clonidine since December 10, 2003, five months earlier.

Robert returned to the pediatric neurologist on April 18, 2005. Ms. Webber reported no problems at that time and Robert saw a counselor.⁴⁵ The doctor recommended Robert return to the nurse practitioner in approximately four to six months. Robert would continue on Adderall and Clonidine. Review of the IDPA records show that Ms. Webber last filled Robert's psychotropic medications on February 18, 2005. She did not refill any prescriptions for the remainder of Robert's placement in her home. Mr. Ford told OIG investigators that he thought Ms. Webber administered Robert's psychotropic medications as prescribed. Mr. Ford thought there might have been medication logs in the foster home, however, he did not recall. Mr. Ford stated that Ms. Webber never complained about having to give Robert his medications. The Omega Agency case record and Alpha Agency licensing record did not contain any medication logs for Robert. When DCP removed Robert from the home of Ms. Webber, Mr. Ford had to refill his psychotropic medications.

Alpha Agency's monitoring of Sacha Webber's foster home

Alpha Agency placed siblings five-year-old Brianna Childs and nine-month-old Anita Banks in the home of Sacha Webber on June 20, 2001. At this time, the children in the home included three-year-old Robert, and Ms. Webber's daughters who were six and two years old. According to Anita's initial health screening, she tested positive for cocaine at birth with previous hospitalizations for ear infection and pneumonia. Anita had bronchitis and also received a referral to be evaluated for developmental delays. At a follow-up medical appointment for Anita one week after placement, the doctor recommended Peditasure to assist with Anita's growth. Anita's doctor's assessment included continued failure to thrive and developmental delays.

The Alpha Agency case manager, Monica Gross, made two home visits in June 2001 to monitor the girls in their new foster placement.⁴⁶ Ms. Webber reported that both girls did well. Over the next six months Ms. Gross conducted four home visits. While in the home, the foster parents reported that the girls continued to adjust to the foster home. By the end of December 2001, Ms. Webber told Ms. Gross that she would love to keep the girls if they could not be returned to their mother.

Sacha Webber becomes legal guardian of her niece, Erica Smithe

In August 2003, Ms. Webber told Alpha Agency licensing representative Ms. Fredrick that she planned to become the legal guardian of her one-year-old niece, Erica Smithe.⁴⁷ Ms. Webber stated that she was not

⁴³ However, from June through August 2002 Ms. Webber did not fill Robert's prescriptions for Adderall. From June through November Ms. Webber did not fill Robert's Clonidine prescriptions.

⁴⁴ Ms. Webber did not return to the neurologist until May 2004, five months later.

⁴⁵ Ms. Webber never took Robert for his Attachment Therapy arranged by Omega Agency.

⁴⁶ Ms. Gross managed the Childs/Banks case from June 2001 through November 2004. Ms. Gross is no longer employed by Alpha Agency and does not work in child welfare.

⁴⁷ On September 23, 2003 a County Judge appointed Sacha Webber the legal guardian of Erica.

concerned about the added stress of an infant.⁴⁸ Ms. Fredrick told OIG investigators that she felt concerned about Ms. Webber's ability to meet Anita's needs with the addition of Erica and attending college. According to Ms. Fredrick, Ms. Webber liked to be busy and appeared to be a strong advocate for the children in her home. Ms. Fredrick stated that Ms. Webber liked the chaos because she was from a dysfunctional home. During a home visit later that month, Alpha Agency case manager Ms. Gross met Erica. Ms. Gross did not document a conversation with Ms. Webber about how the addition of an infant would impact her responsibilities in the home.

Brianna's therapist completed a report on December 29, 2003, that recommended Brianna remain in the home of Sacha Webber. According to the therapist, Brianna experienced confusion about the roles of her foster mother and her biological mother. The therapist assessed that Brianna benefited from the consistency of her foster home.

Anita's special education services

On February 5, 2004, school staff convened a meeting to discuss Anita's progress with special education services. Her gross and fine motor skills improved slowly and staff planned to spend more time on gym activities. Ms. Webber requested eliminating Anita's liquids in the morning because Anita sought drinks for attention. Anita's overall developmental delays continued to prevent her from attending a regular preschool. That same day Anita's preschool teacher completed a school report form and wrote that Anita looked very tired and scared. Some days it appeared Anita cried all morning before coming to school. During the school day Anita drank and ate a lot, with five bathroom breaks a day. School staff observed that Anita urinated during each of the five bathroom breaks. The teacher documented that Anita continued to be late for school and Ms. Webber's explanation for the tardy arrivals seemed unconvincing.

On April 26, 2004, Ms. Gross and Ms. Webber attended a meeting to discuss Anita's IEP goals. Anita's lack of attendance with therapy sessions continued to be a problem. Anita exhibited some delays, was very distractible and had difficulty staying on task. Staff felt that Anita's attention problems might be related to her age. Anita qualified for a bus to transport her to preschool and would continue to receive speech language services. Ms. Webber requested another meeting with the school on May 12 because she felt Anita needed occupational therapy. During the second meeting, the school amended Anita's IEP to include 120 minutes of occupational therapy consultation a semester.

Anita's Evaluation at the Children's Mental Health Center

On April 27, 2004, four months prior to Robert's August 2004 Children's Mental Health Center assessment, Robert's foster sibling was evaluated at the Center.⁴⁹ However it appears that the assessments of the Webber's foster children were not integrated and were conducted in isolation of each other. In Anita's assessment the assessor noted that the foster parent was a full time college student who also worked "some" time out of home as a graphic designer raising six children: nine year-old Maria and four-year old Kim, her biological daughters, Erica her 18 month-old niece and three foster children, forty three-month old Anita the subject of the assessment, eight-year-old biological sister, Brianna and five-year-old foster brother Robert. The oldest two children attended grammar school and "some of the younger children are at daycare maybe 1-2 hours while Ms. Webber attends her college classes." Outside of noting that Ms. Webber attributed Anita's toilet accidents to changes in the "family's attending different churches three times a week," there was no assessment of the parental stress associated with a sole caretaker raising six children under the age of nine. Nor was there an assessment of her support

⁴⁸ With the addition of Erica, Ms. Webber now cared for six children: biological daughters eight-year-old Maria and four-year-old Kimberly and three foster children, seven-year-old Brianna, three-year-old Anita and five-year-old Robert.

⁴⁹ Ms. Webber re-scheduled the assessment on two occasions prior to the April evaluation: January 23 and March 5, 2004.

system including whether there was positive or adverse exchanges between Ms. Webber and her children's father.

Ms. Gross referred Anita for the evaluation because of Anita's history of cocaine and alcohol exposure in utero.⁵⁰ The evaluation included a records review and an interview of Ms. Webber. Ms. Webber informed the evaluator that Anita smeared her own feces, slept approximately five hours a night, refused to nap, and appeared very independent. Ms. Webber reported concerns that Anita had mood swings, a short attention span, did not sit still, appeared cautious in new situations, had questionable interest in other children, and was clumsy.

The medical evaluation concluded that Anita had facial features characteristic of children with prenatal alcohol exposure and she could be considered to have Fetal Alcohol Spectrum Disorder. Anita's history of substance exposure and Fetal Alcohol Spectrum Disorder placed her at risk for developing learning problems, and emotional and behavioral difficulties. Anita's Axis I Diagnosis included developmental coordination disorder, mixed receptive expressive language disorder and phonological disorder. The recommendations included:

- Continue with occupational therapy and speech/language therapy
- Begin sensory integration therapy
- Provide a highly structured, consistent environment
- Adoption subsidy that ensures Ms. Webber has adequate resources for Anita's special needs

Ms. Webber arranged for Anita to receive Sensory Integration therapy from The Children's Center. The Children's Center wrote a letter to Ms. Gross that requested Sensory equipment for Anita totaling \$883. Ms. Fredrick told OIG investigators that SSI and Alpha Agency purchased the sensory equipment for Anita.

During the June 2004 home visit, Ms. Webber told Ms. Gross that she wanted Anita to attend a private school because she was unhappy with the local school district. Previously in March, Ms. Webber discussed the possibility of home schooling Anita. The foster mother also reported that Anita needed sensory integration therapy. Ms. Gross saw Brianna's report card and expressed concern that Brianna missed 10.5 days of school. According to the foster mother, Brianna got sick and the family went on vacation.

Anita's Early Intervention Services

By November 2004 Anita continued to make progress in her therapy sessions. Ms. Webber requested that Anita's rewards during therapy be limited to stickers and not allow her to have candy/drinks during sessions. In December 2004 Ms. Webber attended a therapy session with Anita and reported being impressed with Anita's improvement. The therapist encouraged Ms. Webber to facilitate Anita's independence in the home as well as provide consistent expectations.

On January 20, 2005, Michelle Walker, Alpha Agency caseworker, made a visit to the home of Ms. Webber.⁵¹ According to the foster mother, Anita attended daycare and sensory integration therapy. At this time Ms. Webber considered counseling for Anita because she was stubborn and withdrawn. Ms. Walker spoke to Anita alone, and determined the child seemed to be doing well. Ms. Walker also spoke

⁵⁰ Ms. Gross told the court in a January 13, 2004 hearing that Anita would receive the evaluation at Children's Mental Health Center at the request of her foster mother, Sacha Webber.

⁵¹ The case record did not contain documented home visits for September through December. Michelle Walker assumed case management responsibilities for Brianna and Anita in November 2004.

to Brianna alone. Brianna reported that she felt happy that her biological mother fought to get her back.⁵² When asked about leaving Anita with Ms. Webber, Brianna replied, “she will be fine here.” Ms. Walker told OIG investigators that Ms. Webber appeared calm and able to handle six children as a single parent. The children always appeared well behaved; she met their needs and kept all appointments. Ms. Webber required the children to ask her permission to have a snack or to go into someone else’s room.

By April Anita continued with speech language services, but her attendance at sessions continued to be a problem, out of 55 scheduled sessions, Anita attended 24 (44%). Her therapist surmised that if Anita attended more regularly she might not need services when she began kindergarten in the fall. During a therapy session Anita told her therapist that she still slept in a crib. When the therapist discussed this with Ms. Webber she explained she still used the crib because Anita wandered around at night. Ms. Walker told OIG investigators that in the spring of 2005 Anita no longer qualified for special service fees because of her improved development and that the decrease in money upset Ms. Webber.

During home visits in May and June, Ms. Walker reported that both girls did fine.⁵³ During the visits Ms. Webber updated Ms. Walker on Anita’s special education services. Anita no longer needed occupational therapy, but would always have low muscle tone. Every six weeks Anita received a sensory integration assessment.

On July 26 Ms. Walker met with her supervisor Ms. Durham to discuss the case. According to the case note, the foster home provided both girls with stability. Anita would be enrolled in a regular classroom next year. Ms. Walker planned to change Brianna’s goal to termination of parental rights because the biological mother relapsed.⁵⁴ Brianna and Anita were removed from the home of Ms. Webber two weeks later.

Current Status

Sacha Webber

After the sequence G investigation, DCFS opened a case with Ms. Webber for services. A judge returned her niece Erica to Ms. Webber’s care in December 2005 under an order of protection. During the open case Ms. Webber completed individual counseling, parenting classes and an anger management program. Ms. Webber maintains a two-bedroom apartment for herself and Erica while working full time. Erica attends day care while Ms. Webber works. According to SACWIS case notes completed by her intact worker, Ms. Webber cooperated with DCFS and the requirements of her probation. She has unsupervised visits with her daughters once a week and every other weekend. Ms. Webber has not had any further contact with Robert, Brianna or Anita. In July Ms. Webber surrendered her foster home license with cause.

⁵² Brianna had a goal of Return Home. The biological mother’s rights were terminated for Anita and Ms. Webber planned to adopt Anita.

⁵³ At the June visit, Ms. Walker discussed an issue that occurred between Brianna and Ms. Webber. According to Brianna she got angry with her foster mother who accused her of telling Anita about the visits with the biological mother. Ms. Walker told Ms. Webber that it was not fair to expect Brianna to not talk about the visits with her biological mother. Ms. Webber still did not feel comfortable discussing the return home with Anita, and wanted to wait until Brianna was definitely going home. Ms. Walker did not agree with the decision and planned to discuss the situation with her supervisor.

⁵⁴ There was no documented discussion about how this recent development would effect Brianna or the agency’s plan to share this information with Brianna.

Robert Thicke

Once removed from the home of Ms. Webber, Omega Agency placed Robert with Kaycee Sawyer. Mrs. Sawyer provided respite care for Robert in the past and previously fostered Robert's siblings. The Sawyers have had minimal problems with Robert while in their care. He routinely participates in extra curricular activities such as boy scouts and soccer. He is doing well in school and does not require special education services. On October 6, 2005, seven-year-old Robert returned to the Children's Mental Health Center for a follow-up evaluation. During the assessment, Robert revealed to the examiner "Sacha Webber was mean.... because she always hit us with a paddle." Robert also reported that the abuse occurred during his evaluation one year ago but he did not disclose the abuse for fear of what would happen. However, he admitted that he used to talk about the abuse with his foster siblings. Robert's wishes included for "Sacha Webber to die" and to become a fireman or policeman "so I can arrest Sacha Webber." During the assessment Mrs. Sawyer reported that Robert generally slept through the night with occasional head banging. The examiner opined that some of Robert's previous behaviors may have been attributed to an attachment disorder, but were more likely related to reactions to the abuse he sustained. Robert's Axis I Diagnoses included Posttraumatic Stress Disorder, in partial remission; Attention-Deficit/Hyperactivity Disorder, combined type by history; Rule out Expressive Language Disorder; and Rule out Phonological Disorder. Robert continues to take Adderall and Clonidine and is monitored by Dr. Tower. Robert has also begun individual therapy sessions.

Brianna Childs and Anita Banks

Since their removal from the home of Ms. Webber, Brianna and Anita have been placed in three different foster homes until their placement with Lynn and Carl Adams in March 2006. Prior to their placement with the Adams, both girls had a difficult time adjusting. Brianna had repeated nightmares and told her foster parent about life with Ms. Webber. According to Brianna Ms. Webber used to spank Anita, left Anita, Brianna and Robert home alone, and Anita and Robert were not allowed to have blankets or have drinks of water because they wet the bed. Anita and Robert also wet themselves because Ms. Webber did not let them out of their rooms to go to the bathroom.

According to Jill Durham, Alpha Agency Supervisor, the Adams are a pre-adoptive placement. Brianna and Anita's parents have signed specific consents for their adoption by the Adams. Both Anita and Brianna participate in counseling and System of Care services. Ms. Durham told OIG investigators that the girls are adjusting and no longer ask to see Ms. Webber, her biological children, or Robert. However, both girls have asked about their personal possessions that Ms. Webber has not returned to the agency.

Agency and Institution Licensing Concurrent Investigations

Current Rule and Procedure for 383 Licensure Enforcement holds Agency and Institution Licensing (A&I) responsible for completing concurrent investigations when the State Central Register receives a child abuse/neglect allegation involving a licensed foster home monitored by a private agency.

According to DCFS Procedure 383, Licensing Enforcement:

Upon assignment of a new report of suspected child abuse/neglect, the A&I licensing representative shall begin a concurrent licensing complaint investigation within five days of receiving notification that there will be a formal child protection investigation.

A DCFS Administrator informed OIG investigators that staff at the Central Office of Licensing (COoL) receive a daily printout from SCR that contains the previous day's hotline calls. Staff then manually conducts a Soundex check of each name to determine if the alleged perpetrator(s) are tied to a licensed foster home. According to the Administrator, the data each day can at times contain up to five hundred

names. When staff determines that an alleged perpetrator is connected with a foster home license, that information is forwarded through e-mail to the appropriate A&I Licensing region.

Alpha Agency monitored the license of Sacha Webber during the course of the multiple hotline calls. Alpha Agency holds a statewide license in a county with offices throughout the state. Jose Rodriguez is the assigned Licensing representative for the agency. Evelyn Simms, Office Associate, informed OIG investigators that she receives notification from COoL of a County private agency licensed foster homes with pending DCP investigations. Ms. Simms maintains a database of all notifications forwarded to a county. Ms. Simms stated that she did not have a record of receiving notification of the Sequence B or Sequence F allegations against Ms. Webber. Ms. Simms told OIG investigators that Licensing in a county received notification of the sequence C investigation on January 5, 2004, the Sequence D investigation on July 9, 2004 and the Sequence E investigation on September 7, 2005. Ms. Simms stated that since Ms. Webber's foster home is located outside of a county, she would have mailed a memo and the hotline report information to the appropriate geographical Regional Administrator to request a courtesy investigation. Ms. Simms does not maintain files on the requests for licensing investigations sent to other regions.

Mr. Rodriguez told OIG investigators that he never received notification of the DCP investigations involving Ms. Webber (Sequence B through F). Mr. Rodriguez corroborated the practice to request a courtesy investigation from the appropriate Region. Mr. Rodriguez had no documentation of requests made by the county for a courtesy investigation of the home of Ms. Webber or any subsequent concurrent licensing investigations on the five hotline calls made between June 2003 and February 2005.

The Regional Administrator for Licensing in the Region reported to the OIG that his office did not receive any notifications or requests for a concurrent licensing investigation on the foster home of Sacha Webber.

ANALYSIS

Throughout the time of Anita and Robert's stay with Ms. Webber there was never an integrated assessment of the family's home environment including an evaluation of the foster parent's support system. Not once, even after nine calls to the hotline by concerned professionals, neither Alpha Agency nor Omega Agency convened a clinical staffing to cumulatively review the family's care giving environment. The problems of uncoordinated responses among agencies with split foster care cases have been documented in previous OIG reports.⁵⁵ Rather than removing another child from the home, the involved agencies appeared to ignore growing concerns with an overwhelmed foster parent. Although the scarcity of foster care resources may have been a contributing factor in this case, Robert's biological siblings' foster parents appeared to have been available resources in this case.

Failure to Include Ecological Perspective

Neither of the child welfare agencies nor the outside clinical assessors conducted a valid ecological assessment sampling of Anita and Robert's behaviors across situations and contexts. Instead, the child welfare agencies and outside assessors over relied on the self-reports of an overwhelmed, isolated foster parent in stressful circumstances. Ms. Webber's self-reports became the primary driving force without reliability checks.

While Ms. Webber complained consistently that Robert and his younger foster sibling Anita slept as little as two to four hours a night, the stress factor of sleep deprivation along with the other stress factors of a

⁵⁵ See OIG Reports 03-1162, July 23, 2003 and 06-0339, June 26, 2006.

recent separation and single parenthood, limited income,⁵⁶ educational and work demands (worked part time and attended college full time) were never evaluated as possible contributing factors to the context of her negative reports of Robert's and Anita's behaviors. Research has shown that contributing factors to the failure of parent management training include single-parenthood, lack of support, poverty and family isolation (Dumas & Albin, 1986; Fredrick-Stratton, 1985; Fredrick-Statton, 1995). "Families marked by these risk factors are more likely to drop out of treatment prematurely, fail to show changes after treatment, or fail to maintain changes at follow-up assessments" (Fredrick-Stratton, 1997). Child welfare staff failed to address how Ms. Webber would care for six children as a single parent when Mr. Evans moved out and she obtained guardianship of her one-year-old niece. Further, they never explored with Ms. Webber her report that the family was involved in a contentious custody dispute. The "buffering" aspects of social support to counter Ms. Webber's growing stress were never pursued.

In the month before his third birthday (June 2001) Robert was prescribed Clonidine, six months later he was also prescribed Adderall. Ms. Webber's reports of difficulties managing Robert's behaviors (head banging and inability to sleep thorough the night) were the impetus for the pharmaceutical intervention. However, the foster mother's inconsistent use of Clonidine presented withdrawal risks to a young child and suggests that a medication review should have occurred to ascertain if Robert was over medicated because of the foster parents negative reports.

Anita's early education interventionist and Robert's early interventionist noted Ms. Webber's adverse parenting style and contacted Alpha Agency voicing a concern that Robert was being isolated in his room.⁵⁷ Robert's primary school voiced similar concerns over the foster parent's inflated negativism towards Robert. A concerned foster parent informed one of the child welfare agencies that Ms. Webber's foster children, unlike her biological children, were not allowed to play outside.

Ms. Webber's indicated finding for abuse in the aggressive use of a time-out was seen as an isolated incident with a nine-year-old rather than a symptom of larger concerns. Alpha Agency Licensing did not complete the corrective action plan until four months after the indicated finding and never formally evaluated Ms. Webber's cooperation with outlined tasks. Despite the well documented concerns made by outside professionals for both Robert and Anita, Omega Agency and Alpha Agency staff alike failed to arrange for a clinical staffing to discuss the home and the foster parent's ability to care for the children. Most startling was when Mr. Ford saw Robert's stark bedroom, he accepted this punishing environment and questioned the five year-old if "he liked the smell of urine." The child welfare professionals displayed an unforgivable ignorance of effective empirical based home interventions.⁵⁸ It appeared to outside collaterals that Robert was operating in deprivation. Time-outs used incorrectly can be highly punitive. "Social workers have an ethical obligation to work with a family first to construct a positive family environment. Time-out from a positive reinforcement can work only if there is an environment of reinforcement to begin with."⁵⁹

The rate of complaints involving Ms. Webber expressed by professionals warranted an in-depth individualized intervention in the home to ensure a positive and nurturing home environment, rather than the superficial generic use of training modules and a parenting tape. Parent education in cases of child abuse requires specific in-home coaching to transfer skills learned in parent education to naturally occurring situations in the home (as cited in Mattaini, 1999 p. 250). Evidenced-based practices such as

⁵⁶ Further Alpha Agency licensing failed to assess any additional financial burden of a single parent household.

⁵⁷ From the ages of 3-6 children should remain in a time-out no more than three minutes. Mattaini, M. (1999) *Clinical intervention with families*. Washington, DC: National Association of Social Workers.

⁵⁸ See OIG Report 03-0359, August 18, 2003.

⁵⁹ Mattaini, M. (1999) *Clinical intervention with families*. Washington, DC: National Association of Social Workers.

Fredrick-Stratton's parent management training or multisystemic therapy were never employed. Despite its success in the popular market, the particular parenting tape discipline program violates DCFS licensing rules 402.21g when the training video endorses locking children in rooms as an acceptable disciplinary technique.⁶⁰ In a previous report the OIG recommended the discontinued use of the program after a child died resulting from being locked in a closet.⁶¹ Parents who are in power struggles with their children easily misunderstand the program. Anita and Robert seemed to thrive with the positive reinforcements of early intervention and school. They did not need for their foster parent to utilize time-out procedures rather than positive reinforcements.

Omega Agency and Alpha Agency staff believed Ms. Webber to be a competent, dedicated and committed foster parent who advocated, arranged for services and transported her foster children to appointments, sometimes as much as two hours from the foster home. However, closer inspection of Ms. Webber's cooperation with recommended services revealed a different picture. Anita's early intervention service providers regularly expressed concern about her lack of attendance at developmental therapy appointments, many of which were offered in the foster home. One speech therapist documented that consistent participation by Anita would have resulted in cessation of services much sooner. Robert had poor attendance in preschool and grade school to the point where school officials requested a doctor's note with each absence. Over the years while Ms. Webber described Robert to mental health and medical professionals as angry, physically aggressive, self-destructive, manipulative and anxious, teachers and the school principal described Robert as intelligent, outgoing, enthusiastic, eager to please, warm, affectionate and honest. Child welfare staff failed to recognize the disparity between Robert as described by school personnel and as described by Ms. Webber, even when, his temporary foster parent did not report any difficulties during a pending DCP investigation while Robert lived in a different foster home.

Alpha Agency licensing and Omega Agency caseworkers did not review Robert's prescription bottles or ask for a medication log. All the professionals falsely assumed that Ms. Webber followed Robert's prescribed medication regime even after Ms. Webber reported that Robert's medications did little to address his hyper-activity and sleep disturbances. Most telling is in four of the five months after the Children's Mental Health Center's assessment of Robert, Ms. Webber did not fill Robert's Clonidine prescription.

When Omega Agency contracted for Robert's attachment therapy, a service Ms. Webber advocated for, Ms. Webber never took Robert for the appointment or asked for assistance with transportation. Ms. Webber then went on to report to Robert's primary care physician in April 2005 that he attended therapy with no problems.

Children's Mental Health Center

It does not appear that Alpha Agency or Omega Agency informed the Children's Mental Health Center of Ms. Webber's indicated abuse finding for the maltreatment of a foster child. While the Children's Mental Health Center staff reviewed Robert's IEP they never spoke with Robert's school or Anita's early intervention providers. There also appeared to be a lack of internal coordination between the Children's Mental Health Center's reports on the Webber's foster children. Robert's Children's Mental Health Center assessment did not reference contextual overlap of Anita's assessment or explore whether the foster parent would be overwhelmed either logistically or emotionally with additional recommendations for Robert, given her full time school and the part-time work schedule she reported in Anita's evaluation. Robert's assessment misidentified Ms. Webber's biological children as foster children and the foster children as biological children. Neither assessment gave consideration to the existence or lack of a family

⁶⁰ Rule 402.21, Licensing Standard Discipline of Children, a child may be restricted to an unlocked bedroom for a reasonable period of time. While restricted, the child shall have full access to sanitary facilities.

⁶¹ See OIG Report 94-0131, December 1, 1994.

support system. Robert's assessment identified him as having a Reactive Attachment Disorder and recommended that Ms. Webber engage in Attachment Trauma Focused Therapy "along with her five other children who come from various home settings and are in foster care, in order to facilitate Robert's attachment and adjustment in the home."

The American Academy of Child and Adolescent Psychiatry described within their practice parameters for the Assessment and Treatment of Children and Adolescents with Reactive Attachment Disorder of Infancy and Early Childhood the first order of business for the clinician must be an attempt to make a clinical judgment regarding the appropriateness of the given placement of a child. Since previously maltreated children with negative behaviors are at high risk of being re-traumatized, the clinician's first order of business is to assess the safety of the current placement, consideration of social support and stability, and caregivers' response to previous interventions. It is not uncommon for caregivers of children with Reactive Attachment Disorder to feel disconnected from the child and react with anger or anxiety. Patterns of discipline can become overly authoritarian. In some cases caregivers may be so overwhelmed and angry that coaching is ineffective. When the caregiver's stress is high, sensitive responsiveness to the children cannot be achieved until the caregiver's stress is relieved. In such cases working through the caregiver may be difficult until their own symptoms are addressed.⁶² In addition to the American Academy of Child and Adolescent Psychiatry Parameters, the report of the American Professional Society on the Abuse of Children (APSAC) task force Chaffin, et al (2006) recommends that clinicians gather samples of behaviors across situations and contexts and not be limited to problems in relationships with parents or caretakers. The assessment should include information regarding the child's interactions with multiple caretakers such as teachers, daycare providers and peers with the caution that a diagnosis of RAD "should not be made solely on a power struggle between the parent and child."⁶³

Analysis of Cumulative Information

Taken as single occurrences, the hotline allegations made against Ms. Webber were dismissed by the child welfare professionals. While each of the hotline calls made involving Ms. Webber were unfounded, child welfare should have considered the possibility of increased risk because of an overburdened caregiver. Had Omega Agency and Alpha Agency critically reviewed Ms. Webber's DCP history, they may have been able to better discern the risk to the children left in the home. The number of reports of injuries or mistreatment that occurred in this home, whether indicated or not, should have alerted child protection investigators, case managers and licensing staff to the need for closer scrutiny of this foster home.

When foster parents are the subject of multiple hotline reports, child welfare professionals have a duty to determine the necessity of increased monitoring, protective plans and addressing possible stressors. Analysis of cumulative information, such as corroboration of events and examination of reports across settings, would have afforded the agencies a better understanding of Ms. Webber's home and her ability to care for six children as a single parent.

Licensing Enforcement

It is critical that the divisions of licensing and child welfare be notified immediately of pending abuse/neglect investigation in a foster home. Since documentation was scarce it was impossible to untangle and determine where the notification broke down in this case. The current system of identifying licensed providers with abuse and neglect reports (Central Office of Licensing's manual Soundex

⁶² Boris, Neil W. MD & Zeanah, Charles H MD. (2005), Practice Parameter for the Assessment and Treatment of Children and Adolescents with Reactive Attachment Disorder of Infancy and Early Childhood. *Child & Adolescent Psychiatry* 44 (11), 1206-1219.

⁶³ Chaffin, M. et al. (2006), Report of the ASPAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems. *Child Maltreatment* 11 (1), 76-89.

identification), notifying A&I (emails forwarded by COoL to the appropriate A&I licensing region), and assigning licensing investigations is tedious, cumbersome and prone to failures.⁶⁴ In this case, the process was particularly unwieldy as Alpha Agency, a statewide agency, is licensed as a county agency, but licensing investigative responsibilities are referred to the county in which the foster home is located.

Split Responsibility Cases

In January 2003,⁶⁵ the Inspector General recommended and the Department agreed to discontinue splitting responsibility for the licensed family and their foster children among agencies through the Department's case assignment system. However, private agencies continue the practice outside the formal case assignment system. In a subsequent OIG investigation the Department's response indicates, however, that the Department is not willing to disrupt the case assignment rotation schedule and eliminate shared homes as previously agreed. The Department has maintained that it had adequate controls in place to ensure open communication in split cases. This investigation suggests that whatever procedures are in place are not sufficient. The OIG stands by its prior recommendation that shared homes should be eliminated.

In addition, the Department must address the informal shared homes that result when a private agency uses another agency's foster home. The Department does not have rule or procedures to provide POS agencies with guidance or expectations for the placement of children in the foster homes of another agency and sharing case management responsibility of children in another agency's foster home.

Alpha Agency does not have written policy or procedure to specifically address the placement of children from other agencies into Alpha Agency foster homes or the placement of Alpha Agency children in the foster homes of other agencies.⁶⁶ Alpha Agency reported that as of June 2006, it had a total of 29 shared homes consisting of 35 Alpha Agency children living in 26 foster homes of other agencies and three children from other agencies living in three Alpha Agency foster homes.⁶⁷

⁶⁴ See OIG Report 03-1079, June 30, 2004.

⁶⁵ OIG Report 03-1162, July 23, 2003.

⁶⁶ Source: Senior Associate Executive Director, Alpha Agency.

⁶⁷ See also OIG Report 06-0339, June 26, 2006.

RECOMMENDATIONS

The Children's Mental Health Center

1. The Children's Mental Health Center should incorporate the recommendations of the American Academy of Child and Adolescent Psychiatry and the recommendations of the American Professional Society on the Abuse of Children (APASC) Task force into their assessment practices.
2. This report should be shared with The Mental Health Center.

DCFS

3. Procedure 383, Licensing Enforcement must be revised to address the deficiencies in notification and completion of licensing investigations of licensed foster homes. In 2004, the Inspector General recommended and the Department agreed to have Quality Assurance conduct a review of Central Office of Licensure's method of identifying CANTS reports on licensed foster homes and establishing a schedule of reliability checks for the system of identifying foster homes with a CANTS report (See OIG Report 03-1079, June 30, 2004, Recommendation # 5).
4. Rule 383, Licensing Enforcement, has been in draft form for over a year. The Department should prioritize finalizing the promulgation of this rule.
5. Until a new Procedure is developed, the Department must immediately implement a protocol to ensure needed notification of Licensing and Child Protection investigations to all licensing and child service workers.
6. DCFS licensing standards should require a reassessment of a foster home license when the licensing agency becomes aware of a major change in the family composition, such as a spouse/paramour moving out of the home. The reassessment should include a review of the foster parent's capability to care for the children in light of the loss of a second caretaker as well as the circumstances surrounding the change and any ensuing custody or other legal disputes.
7. The Department should evaluate and address private agencies' practice of sharing homes between agencies for licensing and child welfare placements.

Alpha Agency

8. Alpha Agency licensing should discontinue the use of the parenting discipline videotape and incorporate scientific literature (such as Fredrick-Stratton and Patterson, Reid and Dishion) evidenced-based parent management training and interventions into their licensing corrective action plans for foster parents who demonstrate difficulties managing foster children.

Omega Agency

9. This report should be shared and discussed with Omega Agency case manager Mr. Ford and supervisor Ms. Thomas. Mr. Ford and Ms. Thomas should be disciplined for Mr. Ford's response to Robert Thicke's urinating in his room. Mr. Ford's questioning Robert if he liked the smell of urine, as documented in his July 7, 2005 Foster Home Visit contact sheet, was humiliating and punitive.
10. Omega Agency should train their case managers for specialized foster care in the above scientific literatures to educate them on the differences between positive and punishing interventions.

Appendix One: DCP History of Sacha Webber

Opened	Seq	Narrative	Reporter	Action Taken	Findings	Licensing Action
Sept. 2000	Unk	Two year old Robert had a spiral break of the left humorous	Doctor's Office	Unknown	Expunged	None: No information that Alpha Agency Licensing knew about the incident
Dec. 2001	Unk	Three year old Robert had a bite mark, location not documented	Unknown	Unknown	Expunged	None: No information that Alpha Agency Licensing knew about the incident
12/13/02	A	Vernon (8) had bruising on arm and told reporter Sacha Webber grabs him	School Nurse	Vernon removed from the foster home	Indicated: Cuts, welts, bruises	Alpha Agency completed investigation
6/6/03	B	Robert had a gash on his forehead and explained "mama hit me with the big green gun because I wouldn't stay in bed."	Kelly Smith, Case Manager	Robert removed from foster home during pending investigation	Unfounded	None: A&I never received notification from COoL Alpha Agency knew of investigation from Sacha Webber
12/29/03	N/A	Anita sleeps with her foster parent and stated, "I go potty and I don't get butt spanked."	Anonymous	Licensing Referral	No violations substantiated	Alpha Agency completed a licensing investigation
1/1/04	N/A	Anita has a black eye because she fell down the stairs. No information that injury occurred any other way	Anonymous	Information Only	Not Applicable	None: Alpha Agency Licensing did not know about the report
1/5/04	N/A	Robert told reporter his foster mother spanks him. Anita was shaky at school and staff are concerned about the care the children receive in the home	School Teacher	Information Only	Not Applicable	None: Alpha Agency licensing did not know about the report
1/23/04	C	Robert reports that his foster mother hits him, pushes him down the stairs and does not feed him	Kelly Smith, Case Manager	Formal Investigation	Unfounded	A&I forwarded to Region for courtesy investigation. Receiving Region had no documentation of referral Alpha Agency licensing knew of the investigation.
3/23/04	N/A	Foster mother had gas turned off at her house	Landlord	Licensing Referral	Not Applicable	None: Alpha Agency had no record of the referral for Licensing Investigation
7/9/04	D	Ms. Webber makes her foster children stand in the corner with dirty sock in their mouth and Robert is zipped in a	Anonymous	Formal Investigation	Unfounded	A&I forwarded to Region for courtesy investigation Receiving Region had no documentation of

Opened	Seq	Narrative	Reporter	Action Taken	Findings	Licensing Action
		tent at night				referral Alpha Agency licensing knew of the investigation.
9/2/04	E	Robert had bilateral bruising on neck and ears	School Nurse	Formal Investigation	Unfounded	A&I forwarded to Region for courtesy investigation
2/11/05	N/A	Robert told school Ms. Webber kicked him in his butt that morning and has numerous school absences	School Social Worker	Information Only	None	Alpha Agency Licensing not aware of the report
2/15/05	F	Robert had a bruise on forehead and reported that his foster mother threw food at his head	School Principal	Formal Investigation	Unfounded	None: A&I never received notification from COoL Alpha Agency Licensing not aware of the report

Appendix Two: Table of Psychotropic Medication Compliance

IDPA payouts for Clonidine		
Projected Date Refill Needed	Date Refilled	Overdue⁶⁸
June 15, 2001	June 19, 2001	N/A
July 19, 2001	July 25, 2001	N/A
August 25, 2001	August 23, 2001	N/A
Sept. 23, 2001	Sept. 24, 2001	N/A
October 25, 2001	October 16, 2001	N/A
Nov. 16, 2001	Nov. 12, 2001	N/A
December 12, 2001	December 22, 2001	N/A
January 22, 2002	January 22, 2002	N/A
February 22, 2002	March 21, 2002	1 month
April 21, 2002	April 30, 2002	N/A
May 30, 2002	December 4, 2002	6 months
January 4, 2003	January 4, 2003	N/A
May 2, 2003	June 12, 2003	N/A
July 12, 2003	October 30, 2003	3 Months
Nov. 30, 2003	December 10, 2003	N/A
January 10, 2004	April 30, 2004	3 Months
May 30, 2004	June 2, 2004	N/A
July 2, 2004	July 20, 2004	N/A
August 20, 2004	October 9, 2004	1 Month
November 9, 2004	February 18, 2005	3 Months
March 20, 2005	August 11, 2005	4 Months
Dec. 26, 2001	January 18, 2002	N/A
Feb. 18, 2002	May 3, 2002	2 Months
June 3, 2002	September 2, 2002	3 Months
October 2, 2002	December 4, 20/02	2 Months
January 4, 2003	February 15, 2003	N/A
March 15, 2003	June 13, 2003	3 Months
July 13, 2003	Sept. 16, 2003	2 Months
October 16, 2003	October 30, 2003	N/A
Nov. 30, 2003	December 10, 2003	N/A
January 10, 2004	April 29, 2004	3 Months
May 29, 2004	June 2, 2004	N/A
July 2, 2004	July 20, 2004	N/A
August 20, 2004	Sept. 13, 2004	N/A
October 13, 2004	October 9, 2004	N/A
Nov. 9, 2004	February 18, 2005	3 Months
March 20, 2005	August 11, 2005	4 Months

⁶⁸ Prescriptions not refilled within 30 days of the projected refill date are considered as overdue.

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

REDACTED REPORT

The Office of the Inspector General is releasing this report for training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names, except those of professional references, are fictitious.

File: 06-0304

Minors: Caleb Thomas (DOB 6-03; DOD 8-05)
Michelle Hughes (DOB 2-05)

Subject: Death

SUMMARY OF COMPLAINT

Two-year-old Caleb Thomas died in August, 2005. The autopsy found cerebral edema, subdural hematoma, and retinal hemorrhages consistent with an impact injury as well as contusions and a lacerated liver. The death was ruled a homicide. Police, however, are still investigating this case and no one has been charged. Three months prior to the death there was an unfounded DCP investigation for cuts, welts, and bruises, substantial risk of physical/environmental injury and burns.

INVESTIGATION

Background

Caleb Thomas was born to Maria Miranda and Dwayne Thomas in June, 2003. Three months after Caleb's birth, Tyrell Hughes and Maria Miranda began dating and moved in together. In February, 2005 Maria Miranda gave birth to Michelle Hughes, Tyrell Hughes' child. Until one month prior to Caleb's death, Maria Miranda had been receiving a subsidy for childcare; but when it was discovered that Tyrell was living in the home, the subsidy stopped.¹ Patricia Jones (Tyrell Hughes's mother) began watching the children a few days a week and Tyrell Hughes watched the children the other days. Maria Miranda had been supporting the family by working full time at a nursing home.

Sequence A

Three months prior to Caleb's death, in May 2005, a report was made to the hotline alleging burns, substantial risk of physical injury and cuts welts and bruises to two-year-old Caleb by his mother's paramour, Tyrell Hughes. The investigation was unfounded in June, 2005.

¹ Maria was receiving a childcare subsidy from the TPSN to be used while she was at work. When it was discovered that Tyrell was living in the home and not working, the subsidy stopped.

According to the hotline report, a nurse from Memorial Hospital called the hotline on May 21, 2005 at 8:00 pm and reported that Caleb's biological father, Dwayne Thomas, and his paternal grandmother, Theresa Thomas, brought Caleb to the Emergency Room. The nurse told the hotline that Caleb had a blister extending over two-thirds of his scalp that may be untreated ringworm², an old bruise on his forehead, an old linear bruise along the base of his neck, two circular quarter sized bruises on the mid-back along his spine, a circular burn on the dorsal side of his left hand, a blister on his left medial index finger and swollen eye lids. The hotline accepted the call and opened an investigation. CPSW William Timmons was assigned the case the same day.

Timeline of reported burn incident

While at the emergency room, Maria Miranda told CPSW Timmons that on the morning of Friday May 20, 2005 she took three-month-old Michelle to the babysitter and left two-year-old Caleb at home with her paramour, Tyrell, while she went to work. Tyrell told CPSW Timmons that he awoke between 8:30 and 9:00 a.m. and heard Caleb screaming. When Tyrell went into Caleb's room he found the floor lamp on and lying on the floor. Tyrell told the CPSW that Caleb must have pulled the lamp over and burned himself on the bulb. Initially Maria told CPSW Timmons and the police that all the injuries to Caleb occurred from the lamp falling. Tyrell later revealed that on the previous day, Caleb bumped his head on a rocking chair, causing the bruise on Caleb's head. When questioned by police, Maria confirmed this explanation.

Tyrell also told CPSW Timmons that Friday afternoon Caleb's biological father, Dwayne Thomas, came to visit his son at Maria Miranda's and Tyrell Hughes's apartment. Maria told CPSW Timmons that Tyrell's mother, Patricia Jones, came over after Dwayne and took Caleb home with her that night, Friday, May 20, 2005, because, "she was fearful he was not being treated right."

Maria and Tyrell picked Caleb up from Patricia Jones's house around 4:00 pm, Saturday May 21, 2005. Maria stated that when she saw Caleb she noticed that his forehead was swollen. Patricia Jones told Maria that his forehead was swollen when he woke up that Saturday morning. Patricia Jones advised Maria to watch Caleb for a fever. They returned home and Maria went to Wal-Mart leaving Tyrell home with Caleb and Michelle. On Saturday afternoon Dwayne went to his mother's, Theresa Thomas, house and asked her to come and look at Caleb. When Dwayne's mother, Theresa Thomas saw Caleb, she insisted he be taken to the ER. While Theresa and Dwayne took Caleb to the emergency room, Tyrell waited with Michelle for Maria's return and then went to the emergency room.

According to the Emergency Room records, attending physician Dr. Joseph Kramer observed that Caleb had

"moderate diffuse swelling of the forehead and of the upper eyelids. The swelling was greater on the left side of the forehead than the right and on the left side there were irregular ecchymotic³ areas. There was an approximately two thirds cm area in the anterior part of the top of the head within the hair that appeared to be a second degree burn with broken epidermis that had the appearance of a broken blister. There were mildly erythematous raised areas irregularly across the anterior top of the head on the left side. The back was normal except for an area of mild bruising about two cm in diameter in the right paraspinal area at the lower thoracic level. Notable were second-degree burns on the patient's left hand. There was a 2 cm diameter round burn on the central dorsum of the hand with broken, dried epidermis. There was a firm, unbroken blister with a linear shape to it along the dorsal radial aspect of the patient's proximal index finger and the

² The ER doctors later determined that the blister on Caleb's head was not ringworm but rather a burn.

³ The passage of blood from ruptured blood vessels into subcutaneous tissue marked by a purple discoloration of the skin.

adjacent hand near the second MCP joint. There was bony deformity involving the hand or the fingers.”

Dr. Kramer also noted,

“I expressed my concerns to DCFS and to the police as well as to the mother that the patient was not brought promptly to medical attention, either on the previous day or earlier today when the swelling of the forehead was first noted. The mother’s explanation for how the injury occurred involving the lamp seemed plausible, although unusual to me, but again, the issue of delayed treatment was a concern, and it appeared that the child may not have been brought to medical attention had his father not come for a visit this afternoon. I also found it concerning that the patient’s caregiver on the previous day, the mother’s boyfriend, was asleep in midmorning while the child was awake.”

On Saturday May 21, 2005, at 6:56 p.m. Officer Hanson and Officer Gerwig from the local Police Department arrived at the hospital in response to a complaint of disorderly conduct against Tyrell Hughes. The hospital security worker told the Officers that while Tyrell was in the examining room with Maria, Caleb and Michelle, Tyrell told Maria that he was going to take Michelle outside and sit in their car. When Maria told Tyrell that she wanted Michelle to stay, Tyrell became angry and began swinging Michelle in the carrier while walking towards the exit. When the hospital security worker told Tyrell that Maria did not want Michelle outside, Tyrell yelled, “You people are pissing me off and if you get in my way I’ll run you over!” When Dr. Joseph Kramer told Tyrell that Michelle should remain with her mother, Tyrell put Michelle back in the examining room and then exited the emergency room and stood in the hospital parking lot. The hospital security worker reported that he was alarmed and disturbed by the words and actions of Tyrell. The two Officers went into the hospital parking lot and handcuffed and placed Tyrell in the back seat of the police car. Tyrell Hughes was charged with disorderly conduct and taken to the local Police Department.

Maria told Officer Hanson that on May 20, 2005 Tyrell called her while she was at work to tell her about the burns. Tyrell told her that Caleb had knocked a lamp over and burned himself. Maria told the officer that on May 21, 2005 she observed some liquid running down the side of Caleb’s face. She got a cloth and wiped it off his face. She then noticed a large red spot on his scalp and assumed it was from the incident with the lamp on the previous day.

DCP Investigation

CPSW Timmons arrived at Memorial Hospital at 8:30 pm. When CPSW Timmons observed Caleb, he noted that Caleb had swelling and some discoloration in his forehead area. CPSW Timmons also noted a second-degree burn on the back of Caleb’s left hand and on the side of his left thumb and forefinger. Faded bruises on the middle of Caleb’s back were also noted. CPSW Timmons failed to note the burn on Caleb’s head and did not complete a body chart.

CPSW Timmons and Detective Delacey interviewed Maria in the hospital emergency room. Maria stated there was not a ceiling light in Caleb’s room, so they had a floor lamp in his room. The lamp was about six feet tall, with a single bulb and a plastic globe that is open on the top. The lamp had fallen over in the past and the bulb stuck out past the globe. On Friday May 20, Tyrell called Maria at her work and told her about Caleb burning his hand on the lamp. Maria told CPSW Timmons that she put burn cream on Caleb’s hand when she came home from work. Maria stated that when Patricia Jones (Tyrell’s mother) came over that night and saw Caleb, she pulled Tyrell aside and told him something but was not sure what was said. Maria stated that Patricia Jones took Caleb home with her that night, “because she was not sure what was going on and was fearful that someone was not treating Caleb right.” Maria stated that she and Tyrell picked Caleb up from Patricia Jones’s house around 4:00 pm the next day, Saturday, May 21. Maria stated that when she saw Caleb, she noticed that his forehead was swollen. Patricia Jones told

Maria to watch Caleb for a fever. They returned home and Maria went to Wal-Mart leaving Tyrell home with Caleb and Michelle. When she returned home around 6:30pm Dwayne and his mother had come to the house and taken Caleb to the hospital. When the DCP investigator asked Maria why she did not take Caleb to the hospital, she replied that she was, “afraid of DCFS involvement because things were out of her control.”

CPSW Timmons spoke with the ER treating physician, Dr. Kramer. Dr. Kramer reported that he was concerned because it seemed unusual for all the injuries to have occurred from the lamp falling over and thought it unusual that the lamp would be on at 10:00 am while the caretaker was asleep. He also could not understand why there was a delay in seeking medical treatment. According to CPSW Timmons, Dr. Kramer told him he could not say the injuries were from abuse, but was more concerned about the level of supervision being provided to Caleb.

CPSW Timmons arranged for a care plan to be made with a relative. The investigator first approached Dwayne Thomas, the father of Caleb, but Dwayne told CPSW Timmons that he is a registered sex offender and could not be unsupervised around children.⁴ Maria Miranda suggested that the children stay with her mother, Sandra Miranda. Sandra Miranda was working⁵ at the hospital the day Caleb was brought into the ER. CPSW Timmons approached the maternal grandmother who agreed to not allow unsupervised contact with Maria and no contact with Tyrell. The grandmother told CPSW Timmons that she did not have any concerns about Maria or Tyrell’s care of the children.

CPSW Timmons told OIG investigators that after his initial interviews, it was not clear as to how the older bruise on Caleb’s head occurred. While at the ER, Maria initially alleged that all the injuries occurred on the same day from the lamp. Then on May 25, 2005 CPSW Timmons spoke with Detective Delacey from the local Police Department. The Detective told the investigator that he had interviewed Tyrell and found that the bruise to the forehead was from an incident the day prior to the burn. Tyrell told the detective that Caleb had fallen head first into a wooden rocking chair. Tyrell also told the detective that Maria had kept Caleb home with him on the day of the burn incident because she was afraid the baby sitter would see the bump on Caleb’s head and call DCFS. The detective told CPSW Timmons that two events make it a more understandable history of how multiple injuries could have occurred. The Detective said that he spoke with Maria after interviewing Tyrell and she corroborated the story.

CPSW Timmons told OIG investigators that he did not recall talking to the doctor a second time to discuss the rocking chair as a possible explanation for the forehead injury. CPSW Timmons told OIG investigators that he assumed Detective Delacey had contacted the doctor. DCP Supervisor Joseph Benson also stated that he was under the impression that the detective had contacted the doctor. When OIG investigators spoke to Detective Delacey, Delacey stated that medical personnel had not been consulted to confirm the plausibility of the bruise occurring from Caleb falling into a rocking chair.

On May 26, 2005 CPSW Timmons interviewed Tyrell at the family’s residence. Tyrell told CPSW Timmons that he and Maria had been together for about one year. Tyrell reported that Caleb had bumped his head the day before the burn. Tyrell was not present when it happened, but Maria told him that Caleb was playing and fell head first into a wooden rocking chair. Tyrell told CPSW Timmons that after the burn incident, he suggested to Maria that they take Caleb to the doctor, but Maria was afraid DCFS would be called. Tyrell reported that on Friday Maria took Michelle to the babysitter and Caleb stayed home because Maria was afraid the babysitter would see the bruise on Caleb’s head and call DCFS. Tyrell said

⁴ OIG conducted a LEADS, which identified that Dwayne Thomas had been charged and pled guilty to aggravated criminal sexual abuse in January 2004 and again for a different victim in May 2005.

⁵ Sandra Miranda works as a clerk in Information Services at Memorial Hospital.

that he awoke between 8:30 and 9:00 am and heard Caleb screaming.⁶ When he went into Caleb's room he found the lamp on and lying on the floor. Tyrell said that Caleb must have pulled the lamp over and burned himself on the bulb. Tyrell told CPSW Timmons that Maria took Caleb to the pediatrician, Dr. Winters, on Monday May 23, 2005. According to Tyrell the doctor told Maria that he would not have taken the child to the doctor because the injuries were not that serious and they should have just put ice on Caleb's head.

According to CPSW Timmons's contact notes, he attempted to call Dr. Winters' office on June 6, 2005 and June 17, 2005. CPSW Timmons told OIG Investigators that he usually makes two attempts when contacting medical personnel. DCP Supervisor Joseph Benson told OIG Investigators that he was surprised that CPSW Timmons did not talk to Dr. Winters because he is very accessible and donates time at the CAC. Dr. Winters told OIG Investigators that there have been problems with his office's reception and it is possible that CPSW Timmons left a message for him, but he did not receive the message. Dr. Winters also stated that he donates his time one day a week at the CAC and can be contacted there. Dr. Winters' medical notes reflect that he was concerned because of the multiple injuries and the delay in seeking treatment.

DCP Supervisor Joseph Benson instructed CPSW Timmons to go to the apartment and reenact the incident. CPSW Timmons told OIG Investigators that on May 26, 2005 he went to the apartment and observed the lamp and noted that it was tall and flimsy with the plastic globe on the top of the lamp open, which exposed the bulb. CPSW Timmons noted that it would be easy for a child to pull the lamp over. According to the CPSW, the lamp would have either fallen on the floor in front of Caleb's bed or would have landed on furniture if it had fallen in any other direction. CPSW Timmons told OIG Investigators that Tyrell told him that the cord to the lamp ran across the floor and Caleb must have tripped on the cord, causing the lamp to fall on top of him. The investigation contains no mention of where the cord was plugged into the wall. CPSW Timmons told OIG Investigators that he did not reenact that aspect of the story to see if that explanation was possible.

Also, on May 26, 2005 CPSW Timmons met with Maria, Tyrell and the maternal grandparents at the maternal grandparents' home to terminate the safety plan. According to the investigator, the injuries to the children were determined to be accidental. CPSW Timmons appeared to focus only on the bump on the forehead and the burn on the hand. The spinal bruising, scalp burn and finger burn were never discussed in the rationale of unbounding the DCP investigation.

On June 17, 2005 a supervision note is recorded from Supervisor Joseph Benson, which noted, "there were no prior indicated reports, initial statements were consistent with the injuries and further investigation resulted in confirming two incidents both plausible in nature. Collateral and involved subjects deny abuse. Once medical personnel were advised of two incidents doctor could not rule in abuse could be an accident. Supervisor to approve waiver requests and site manager to approve checklist d/t burn allegation. Unable to establish an incident of real and significant danger."

Inconsistent Account of Events

Date	Account of Events
5/21/05	<ul style="list-style-type: none"> • Maria told CPSW Timmons all the injuries occurred from the lamp falling over. • Tyrell told Dr. Kramer that he woke up at 10:00am and heard Caleb screaming. Tyrell also told the doctor that all the injuries occurred from the lamp falling over. • Tyrell told the police that he woke up at 11:00 am and heard Caleb screaming. Tyrell

⁶ Tyrell told the ER treating physician that the incident took place at 10:00am and he told the police officers the incident occurred at 11:00am.

	also told police that all the injuries occurred from the lamp falling over.
5/25/05	<ul style="list-style-type: none"> • Maria told CPSW Timmons that prior to the burn incident Caleb had fallen head first into a rocking chair, causing the bruise on the head. • Tyrell told the police that prior to the burn incident Caleb had fallen head first into a rocking chair, causing the bruise on his head.
5/26/05	<ul style="list-style-type: none"> • Tyrell told CPSW Timmons that he woke up between 8:30 am and 9:00 am and heard Caleb screaming. Tyrell told CPSW Timmons that the bruise on Caleb's head occurred the day prior to the burn when Caleb fell head first into a rocking chair. Tyrell also told the CPSW that Dr. Winters told Maria that the injuries were not that serious and they should have just put ice on the injuries.

The Children's Advocacy Center

The local Children's Advocacy Center's protocol is to review any priority one/serious injury and burn cases. The investigators fax a report to the CAC and the CAC arranges the case review with the State's Attorney, police, CAC staff, and DCFS. According to a representative from the CAC, "the case reviews provide professional consultations and discusses service needs."

CPSW Timmons told OIG Investigators that the case had been reviewed by the CAC prior to the case closing. Timmons told OIG investigators that, "this is an automatic for priority one serious injury cases, such as burns." After contacting the CAC, the OIG was informed that this case had not been reviewed by the CAC prior to Caleb's death. During a follow-up interview, CPSW Timmons told OIG investigators that, "the CAC must have only reviewed the case after the death."

OIG Investigators interviewed the lead forensic interviewer, Ms. Newcomb, at the CAC. Ms. Newcomb stated that, "per our protocol this case should have been reviewed by the CAC since it was a burn case. However, we never received a request from the investigator to review this case." According to documentation provided by the CAC, there was a meeting held on June 13, 2005 with CPSW Timmons, Detective Delacey, and Dr. Winters by phone.⁷ This meeting was not a formal CAC case review. When asked about this meeting, CPSW Timmons stated that he could not recall this meeting. Dr. Winters told OIG investigators that he could not recall this meeting specifically, but remembers telling someone from DCFS that he was suspicious as to the nature of the injuries. Detective Delacey also told OIG investigators that he could not recall this meeting.

Medical

OIG Investigators interviewed Caleb's pediatrician, Dr. Winters. Dr. Winters reported that Maria brought Caleb into his office for a follow-up visit after the burn incident. Dr. Winters reported that he thought the burn on the back of Caleb's hand was a 3rd degree burn.⁸ Dr. Winters explained, "I thought the lamp explanation was very suspicious. If a child is mobile, like Caleb, they would not let the bulb stay on them, they would move away. Also, this does not explain how he received the burn on the back of his hand. The research tells us that a burn on the back of a child's hand runs a high risk for abuse." Dr. Winters also stated that in July 2005 Maria and Tyrell brought Caleb into his office. Dr. Winters was surprised to see Caleb with Maria and Tyrell, so he called DCFS, but no one returned his call. Dr. Winters told OIG Investigators that he would not be opposed to having Michelle returned to the care of her mother, Maria Miranda.

⁷ The CAC often provides a meeting place for DCFS employees to meet with professionals such as doctors and police.

⁸ The ER doctor thought it was a 2nd degree burn.

Prior Medical Records

The OIG subpoenaed medical records from Caleb’s primary care physician, Dr. Winters and Memorial Hospital, where Caleb was brought into the ER for the burn incident. According to the medical records obtained from Memorial Hospital, when Caleb was 6 months old in January 2004, he was brought into the ER and diagnosed with Blunt Head Trauma caused by rolling off the bed and falling on his back onto the hardwood floor. Almost a year later in March 2005, he returned to the ER because he was shaking uncontrollably. He was diagnosed with Acute Ataxia, which can occur following a viral infection. Two months later on May 21, 2005, Caleb was brought into the ER because of burns on his hands, a burn on his head and a bruise on his head.

Caleb was a patient of Dr. Winters’ since his birth. According to medical records obtained from Dr. Winters’ office, Caleb was up to date on all of his shots and followed up with Dr. Winters after most ER visits. In January 2005 Caleb was brought to see Dr. Winters because of a cough and runny nose. On this record a question asked was, “Have there been any recent injury/illnesses?” the record stated “burn to left hand approximately one month ago.” In May 23, 2005 Dr. Winters documents a visit following the burn and bruise incident that initiated DCFS involvement. Dr. Winters states that he is, “concerned because of both injuries and the delay in seeking care...agree needs to be investigated.”

Date	Reason	Diagnosis	Doctor	Other
1-23-04	Fell off bed onto hardwood floor	Blunt Head Trauma	Dr. Winters (Primary)	
1-13-05	Cough and Runny Nose		Dr. Winters (Primary)	Noted, burn to left hand
3-28-05	Shaking Uncontrollably	Acute Ataxia	ER and Dr. Winters	
5-21-05 5-23-05	Burns on head/hand Bruise on head	ER: 2 nd Degree Burns Primary: 3 rd Degree Burns	ER and Dr. Winters	DCFS Investigation Unfounded

Unfounding of the investigation

According to the DCP investigation the rationale given for unfounding this case consisted of, “Caleb Thomas was brought to the ER with a hematoma or bruise and swelling to his forehead. At first the only incident that was talked about was an incident where the child had pulled a lamp over in his room, which accounted for a burn to his left hand, but did not seem to explain the bruise to the forehead. Further information from the parents brought to light that there had been another occurrence the day before, where Caleb had been playing in the living room, and fallen forward into the side of a wooden rocking chair. The injury appears to be consistent with this history and helps explain the presence of the two areas of injury, which at first were perplexing. Ms. Miranda and Mr. Hughes both deny having harmed Caleb and maintain that the child’s injuries were accidental in nature. Family collaterals shared no concerns regarding the care of the children. There are no prior indicated reports of abuse or neglect involving Ms. Miranda and Mr. Hughes. In regards to the allegation, this case is determined to be unfounded.”

When Timmons first arrived at the Emergency Room on May 21, 2005, he observed Caleb to have swelling in the forehead area and some discoloration. CPSW Timmons also noted a second-degree burn on the back of Caleb’s left hand and on the side of the left thumb and forefinger and faded bruises on the middle of his back. Timmons told OIG investigators that he did not know why in his rationale for unfounding this case the burn to the back of the hand and the bruise on the head were the only injuries mentioned.

When the OIG asked Timmons to explain his rationale for unfounding this investigation, CPSW Timmons stated, “There had been no priors and there were two explanations for the two incidences. Joe told me to go to the apartment and do a reenactment.” OIG asked how he knew these were plausible; Timmons reported, “through medical personnel and Delacey.” OIG asked how Timmons knew medical personnel had reviewed this rationale, Timmons reported, “I was under the impression that Delacey had talked to the physician.” Supervisor Joseph Benson also told OIG Investigators that he was also under the impression that Detective Delacey had talked to the physician.

OIG Investigation

When asked if Timmons received the medical records, he stated, “I believe we received medical records for the ER visit.” OIG asked if Timmons would ever request medical records from the pediatrician, Timmons replied, “if it was a serious head injury, shaken baby, when a medical history is reported, or for medical neglect cases.”

When asked to explain his understanding of the paramour policy, Timmons replied, “conduct background checks, review priors, and make a safety arrangement. OIG asked about collateral contacts, Timmons replied, “I spoke to Maria’s parents, Dwayne Thomas and his mother, Theresa.” OIG asked why there was not a case note for Theresa, Timmons replied, “she must have left before I interviewed her. OIG asked if the babysitter, Margie Moody, had been contacted, Timmons replied, “I can’t recall talking to her.”

OIG Investigators asked Supervisor Joseph Benson what collateral contacts he requires of his investigators, “I stress that as many collaterals as possible should be contacted. I try not to waive collaterals, but because of caseload sizes, there is always a push for closing CERAPS.”

Both CPSW Timmons and Supervisor Joseph Benson expressed concerns regarding the size of caseloads in the Local area. At the time the first investigation was assigned to CPSW Timmons, he had nineteen pending investigations and twenty pending investigations at case closing. In the month of May 2005, when the Caleb Thomas case came in, CPSW Timmons was assigned twenty-four investigations. Joseph Benson stated they are in the process of addressing this issue by hiring five new investigators. The following chart demonstrates cases assigned and completed at the time the first investigation was opened and closed.

Month 2005	Assigned Investigations	Completed Investigations
April	12	13
May	24	19
June	9	14
July	16	18
August	19	9
September	21	21

OIG investigators asked paternal grandmother, Theresa Thomas, if she ever had any concerns prior to the burn incident. Ms. Thomas stated that she knew Tyrell had a temper, but he had always been polite towards her. Tyrell and Dwayne had been high school classmates. When asked if she had been contacted by DCFS prior to the death, she stated that she only spoke to the police. Ms. Thomas told OIG Investigators that when she saw Caleb after the burn incident, he looked like he had been beaten. Theresa stated when she asked that Caleb be taken to the ER, Tyrell was insistent that Caleb not be taken. Tyrell told Theresa that, “Maria would kill him if Caleb is taken to the ER.”

Death

Caleb Thomas died in August 2005. Michelle Hughes was initially taken into custody and placed with her grandmother (Tyrell's mother, Patricia Jones). In November 2005 Michelle was placed in a traditional foster home.

Tyrell Hughes was caring for two-year-old Caleb and five-month-old Michelle on the day of Caleb's death. Maria Miranda reported that she left for work around 6:00 am. Tyrell Hughes told the DCP Investigator he woke up around 9:30am and noticed Michelle sleeping. Tyrell then went to check on Caleb. Tyrell picked Caleb up and took him into the kitchen. According to Tyrell, Caleb appeared to be moving slow and whining. Tyrell then gave Caleb a teaspoon of Motrin, as instructed by Maria. Tyrell then put Caleb back to bed. Around 12:00 pm Tyrell went to check on him and noticed he was sleeping hard, so he picked him up and laid him back down on the bed in Tyrell and Maria's room. As he began walking away, he noticed Caleb's mouth was blue. Tyrell then picked him up and held his ear to Caleb's chest. When he did not hear a heartbeat, he shook Caleb. He called Maria's work and then 911. The 911 operator instructed him on how to do CPR until the paramedics arrived.

The doctor at the hospital told the investigator that the fatal injuries had been inflicted on the day of the death. The doctors found internal injuries and bruises on many parts of the body in various stages of healing. The autopsy found cerebral edema, subdural hematoma, and retinal hemorrhages consistent with an impact injury, as well as contusions and a lacerated liver. An area of older congealed blood was found, possibly indicating an older subdural hematoma.

At the hospital on August 7, 2005, Patricia Jones, Tyrell's mother, told the on call investigator that bruises on Caleb were an ongoing concern. Ms. Jones stated that she had been worried, so she decided to take Caleb for a couple of days. The Sunday before he had a cold and was running a fever off and on all week. She noticed that Caleb was lethargic, sleeping a lot and she thought his lips looked a little bit blue. She had asked Maria Miranda if he had been eating any candy that would have left a stain on his mouth. She said that Caleb improved on Thursday. Maria told DCP that she stayed home on Wednesday, Thursday and Saturday because Caleb was ill.

Tyrell had been caring for the children during the day on a regular basis for about one month prior to Caleb's death. Tyrell admitted to the DCP investigator that he had been smoking marijuana on a regular basis. Tyrell also told the DCP investigator that two days prior to the death in August 2005, he had been watching the kids and Caleb got up on a chair and fell off, which caused a bruise on his forehead and a cut to his lip.

Maria's parents, Sandra⁹ and John Miranda, and a neighbor told the DCP investigator that there had been domestic violence between Maria and Tyrell in the past. When Tyrell was asked about domestic violence, he denied it. Maria refused to be interviewed by DCFS on advice of her attorney.

Sherri, a girlfriend of Tyrell's best friend, told the DCP investigator that bruises on Caleb increased when Tyrell began watching the children. She said that Tyrell would often leave the children alone in the apartment while he was in the parking lot. Sherri had told Tyrell to bring the kids to her, rather than leave them alone. Sherri saw Caleb with a black eye around the time of the burn and again about a week before he died. Tyrell would either tell Sherri that he got hurt playing or he was not sure what had happened. Sherri said she saw Caleb the day before he died and asked Maria if she was going to take him to the hospital, but Maria said she was taking him to the doctor on Monday August 7, 2005. Sherri reported that when Tyrell would get angry he would hit things (hitting walls, kicking doors, windows), but she had

⁹ During the unfounded investigation, Maria's mother, Sandra Miranda told CPSW Timmons that she did not have any concerns regarding Tyrell and Maria.

never known him to hit a person. The apartment manager confirmed that two doors had been kicked in. The manager also corroborated that Tyrell was often out in the parking lot. The manager assumed the children were asleep and Tyrell felt comfortable leaving them in the apartment.

The prior daycare provider, Margie Moody from Hayes Park, confirmed Caleb's last day was June 30, 2005. Margie told the DCP investigator, due to the safety plan she did not see the burns from the first investigation until one week after the incident. When she saw the burns she thought the falling lamp story was suspicious. Margie also told the investigator that she had never noticed bruises on Caleb that seemed inappropriate for a child his age.

As part of Tyrell's probation for an armed robbery charge, Tyrell attended a weekly Young Father's group at a local social service agency. Tyrell's probation officer sent him to HELP to attend Career Core, but because of his young age and having two children to take care of, he was assigned to the Young Father's group. The program director reported that Tyrell would come almost every week. They would have dinner for the fathers and kids, and then they would provide daycare to meet with the fathers for about an hour. He thought Tyrell had always interacted well with the children. According to Tyrell's probation officer, the reports she received from HELP stated that Tyrell was cooperative, but only attended 50% of the time.

The DCP investigator also interviewed Tiffany, who attended parenting groups with Tyrell. Tiffany stated that after group, Tyrell told her that he and Maria wanted to give the kids up to her uncle out of state because he did not like kids and did not know how to take care of them. Tiffany also stated that some of the girls in the group would comment on how Caleb would show up with new bruises every week.

The DCP death investigation is still pending as of September 2006.

ANALYSIS

Whenever a child is injured, a critical analysis of the facts is required, whether the injury is the result of abuse, neglect, or an accident. CPSW Robert Timmons and DCP Supervisor Joseph Benson failed to perform such critical analysis during the DCP Investigation.

Failure to conduct a thorough investigation

When assessing whether an injury to a child is abusive or accidental, it is essential that the investigator consider all the information gathered during the course of the investigation. For example, any burns, which occur with one or more of the following, should have a complete examination for abuse (Smith, 1989):

- A history non-compatible with the physical findings.
- A burn incompatible with the developmental age of the child.
- Burns assessed as older than the historical account.
- Unrelated hematomas, lacerations, and scars.
- An adult unrelated to the incident seeking medical attention.
- Treatment delay of 24 hours or more.
- A previous history of burns.

When viewed individually, any one of the following events may not be cause for concern. However, when collectively analyzing these events, the investigator should have been more concerned about the care being provided to Caleb. CPSW Timmons failed to critically assess the following concerns:

- Caleb was not immediately brought to medical attention.

- Caleb was not brought to the hospital by his primary caregivers, but rather his father and paternal grandmother. It is likely that if Caleb’s paternal grandmother had not insisted on bringing him to the hospital, he would not have been brought at all.
- Several injuries to Caleb were not noted as having occurred as a direct result of the lamp falling (i.e. faded bruises on the back, bruises and swelling on the forehead).
- Maria and Tyrell’s inconsistent explanations for how the injuries occurred.
- While at the emergency room, Tyrell displayed aggressive acting out behavior and was charged with disorderly conduct.
- Everyone interviewed, including Maria, admitted to Maria’s fear of DCFS.
- Caleb had a burn on the back of his hand indicating a “defensive” rather than a “grabbing” injury (Hobbs, 1986).

Failure to critically assess the mechanics of the injuries

A scene investigation conducted at the scene of the incident can reveal valuable data. DCP Supervisor Benson told CPSW Timmons to conduct a reenactment of the alleged incident. CPSW Timmons went to the apartment and observed the lamp and the environment; however, failed to “reenact the incident.” During a scene investigation or reenactment, the environmental circumstances surrounding the incident should be specifically noted. The people, objects, times, and distances should be detailed (Scalzo, 1994).

CPSW Timmons told OIG investigators that while at the apartment, Tyrell stated that the cord ran across the middle of the floor and Caleb must have tripped on the cord causing the lamp to fall on him. This explanation was not documented in the DCP investigation. Also, the pictures taken by the police department do not display a cord running across the floor of the room and Detective Delacey stated that he recalls plugging the lamp into the wall near the lamp and does not recall a cord running across the floor. CPSW Timmons stated that he did not reenact this aspect of the story.

During a scene investigation, the investigator should seek to fully assess how the reported incident occurred, as well as consider other possible means by which the incident may have occurred. It is vital that the investigator not assume that the reported explanation is accurate.

Failure to recognize inconsistent explanations

One significant risk factor for abuse is a changing history (Hobbs, et.al., 1999). Maria and Tyrell first reported to hospital personnel, CPSW Timmons, and the police that all the injuries to Caleb occurred on the same day from the lamp falling over. While Caleb was at the ER, Dr. Kramer told CPSW Timmons and Detective Delacey that, “it seemed unusual for all the injuries to have occurred from the lamp falling over.” Once Tyrell and Maria reported that Caleb had previously fallen head first into a rocking chair, this scenario was viewed as factual and the change in history was not viewed as inconsistent or suspicious. CPSW Timmons failed to recognize that a change in history is a risk factor for abuse. The following chart demonstrates the different explanations given by Tyrell and Maria during the course of the investigation:

Date	Account of Events
5/21/05	<ul style="list-style-type: none"> • Maria told CPSW Timmons all the injuries occurred from the lamp falling over. • Tyrell told Dr. Kramer that he woke up at 10:00am and heard Caleb screaming. Tyrell also told the doctor that all the injuries occurred from the lamp falling over. • Tyrell told the police that he woke up at 11:00 am and heard Caleb screaming. Tyrell also told police that all the injuries occurred from the lamp falling over.
5/25/05	<ul style="list-style-type: none"> • Maria told CPSW Timmons that prior to the burn incident Caleb had fallen head first into a rocking chair, causing the bruise on the head. • Tyrell told the police that prior to the burn incident Caleb had fallen head first into a

	rocking chair, causing the bruise on his head.
5/26/05	<ul style="list-style-type: none"> • Tyrell told CPSW Timmons that he woke up between 8:30 am and 9:00 am and heard Caleb screaming. Tyrell told CPSW Timmons that the bruise on Caleb's head occurred the day prior to the burn when Caleb fell head first into a rocking chair. Tyrell also told the CPSW that Dr. Winters told Maria that the injuries were not that serious and they should have just put ice on the injuries.

Failure to consider all the injuries

When CPSW Timmons first observed Caleb in the emergency room, he noted that Caleb had swelling and some discoloration in his forehead area. CPSW Timmons also noted a second-degree burn on the back of Caleb's left hand, on the side of his left thumb and forefinger and faded bruises on the middle of Caleb's back.

If CPSW Timmons had reviewed the ER records and/or the pediatrician's records, he would have found that Caleb also had a second-degree burn on his head. Although CPSW Timmons observed several injuries to Caleb, he failed to consider all the injuries in his rationale for unfounding this investigation. CPSW Timmons only sought an explanation for the burn on the back of Caleb's hand and the bruise on his head.

It is also important for investigators to consider risk factors for abuse to children in relation to the injuries sustained. For example, inflicted contact burns tend to result in a more sharply defined pattern with a recognizable shape and are deeper. Accidental contact burn patterns tend to be less well defined because of the child's ability to move away from the hot object in response to pain, resulting in a more superficial burn (Horner, 2005). The burn sustained on the back of Caleb's hand reflected that of an inflicted burn rather than an accidental burn. Also, burns to the back of a child's hand often reflect that of an inflicted burn rather than an accidental burn (Hobbs, 1986).

Failure to seek medical consultation

When Maria and Tyrell changed their explanation for how the injuries to Caleb occurred, CPSW Timmons failed to seek medical consultation to determine the plausibility of the explanation. Both CPSW Timmons and DCP Supervisor Benson assumed Detective Delacey had consulted with medical personnel. Detective Delacey told OIG investigators that he did not consult medical personnel.

CPSW Timmons also failed to interview Caleb's primary care physician, Dr. Winters. Although CPSW Timmons reportedly left two messages at the office of Dr. Winters, it was later discovered that Dr. Winters is easily accessible through the CAC. Dr. Winters' office is also located two miles from the local field office. DCP Supervisor Joseph Benson waived this contact; however, reported to OIG investigators that had he realized the primary care physician was Dr. Winters, he would not have waived this contact.

Had CPSW Timmons interviewed Dr. Winters, he would have discovered that Dr. Winters was very suspicious of the reported incident. CPSW Timmons also would have discovered that Tyrell was not telling the truth when he stated that Dr. Winters told Maria that the injuries were not that serious.

Failure to consider Tyrell's behavior

It is important to consider all factors when assessing the possibility that someone in the household may be harming a child. For example, when an individual's demeanor presents itself as being violent or aggressive, it is important that the CPSW thoroughly investigate the individual through collateral contacts and LEADS checks.

While at the emergency room, Tyrell tried taking two-month-old Michelle out of the examining room. When Maria and the doctors told Tyrell to leave Michelle, Tyrell began acting out by yelling at hospital

personnel and swinging Michelle and the carrier. Police were called and Tyrell was arrested and charged with disorderly conduct. This behavior should lead the investigator to suspect there may be violence in the home. CPSW Timmons failed to consider Tyrell's behavior as cause for concern.

Failure to make required collateral contacts

When a report of suspected abuse or neglect is alleged, it is important that the investigator make collateral contacts with individuals who can provide information concerning:

- safety and well being of the children
- parental functioning
- quality of the home environment
- quality and stability of the relationship between the caregivers

It is important that investigators not rely on one collateral contact, but rather multiple contacts should be made to obtain a more accurate depiction of the situation. Information can be obtained by interviewing:

- extended family members
- child care providers
- neighbors
- school or daycare personnel
- medical personnel.

The only collateral contact made during the course of the DCP investigation was Caleb's maternal grandmother, Sandra Miranda. Sandra Miranda told the investigator that she did not have any concerns regarding the care being provided to Caleb. After the death, Sandra Miranda revealed that there had been domestic violence in the past and that Tyrell often treated Caleb differently than Michelle. CPSW Timmons failed to make multiple collateral contacts.

During the course of the DCP investigation, CPSW Timmons learned that Caleb and Michelle had been going to daycare on a regular basis while Maria was at work. According to Procedure 300, the investigator must interview schoolteacher or childcare provider who has knowledge of the child and/or the level of care provided to the child. CPSW Timmons failed to contact the daycare provider, Margie Moody.

Caleb was brought to the emergency room by his father, Dwayne Thomas, and his paternal grandmother, Theresa Thomas. When CPSW Timmons interviewed Dwayne Thomas, Dwayne told the CPSW that Theresa Thomas had insisted Caleb be brought to the hospital. CPSW Timmons failed to interview Theresa Thomas.

Throughout the DCP investigation, Maria and Tyrell mention several times that Patricia Jones had been concerned about the care being provided to Caleb and took Caleb home with her after the burn incident because she was afraid someone was hurting Caleb. CPSW Timmons failed to consider interviewing Ms. Jones.

Failure to notify the Child Advocacy Center

According to department procedure¹⁰ child protection investigations of burns should be, "conducted under the auspices of the local Child Advocacy Center, when available." The local CAC provides professional consultations regarding DCP investigations. According to the CAC, their protocol is to be available to review all serious injury, including burn injuries to children.

¹⁰ Procedures 300, Appendix B-Allegation: Burns.

The CAC, Supervisor Benson and CPSW Timmons all reported that it is the child protection investigator's responsibility to notify the CAC when serious injury cases, including burns. CPSW Timmons failed to refer Caleb's case to the CAC.

Caseload Concerns

A child protection investigator exceeds B.H. caseload levels if he/she has been assigned more than fifteen (15) investigations in any month during the current calendar year or more than twelve (12) investigations during nine months of the current calendar year.

CPSW Timmons's high caseload levels impact the number of hours he is able to devote to any single investigation. CPSW Timmons had been assigned twenty-four cases the month that he was assigned the Caleb Thomas case.

Expungement of Records

In the case of Caleb Thomas, the previous unfounded DCP investigation was expunged while the death investigation was still pending. When investigating allegations of abuse and/or neglect, investigators should have access to as much background information as possible. When a family has had previous involvement with the Department, investigators can gain valuable information that will assist in making a determination of indicated or unfounded.

According to ANCRA,¹¹ the Department may retain previous child protection investigations on the Register when there is a new child protection investigation pending.

RECOMMENDATIONS

- 1) *[Discipline was recommended.]*
- 2) *[Discipline was recommended.]*
- 3) Child Protection management should immediately review caseloads at the local Field Office to determine if the problems with B.H. limits have been remedied.
- 4) The Department should ensure that child protection investigations, both unfounded and indicated, are not expunged while a subsequent investigation, involving the same family, is pending.
- 5) Department Procedure 300.70, "Referrals to the local law enforcement agency and State's Attorney" should be amended to include second-degree burns as injuries requiring referral to local law enforcement and the State's Attorney.
- 6) This report should be shared with the State's Attorney currently involved in reexamining this case.

¹¹ ANCRA, 325 ILCS 5/7.14.

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