OFFICE OF THE INSPECTOR GENERAL
Illinois Department of Children and Family Services

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

JANUARY 2004

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Inspector General

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Office of the Inspector General
Illinois Department of Children and Family Services

January 1, 2004

To Governor Blagojevich and Members of the General Assembly:

In FY 2003, the Department of Children and Family Services served 16,000 fewer family and child cases than it served in FY 1999 and had 7,500 fewer children in substitute care. Yet the number of death cases meeting the criteria for review by the Office of Inspector General (families having involvement with DCFS in the year prior to the child's death) has increased over the same five years, from 82 child deaths in FY 1999 to121 child deaths in FY 2003. Is it reasonable for us to inquire if it is possible to lower the mortality rates of these children? I believe it is not only reasonable but also prudent for us to look closely at our death reviews and investigations to explore prevention strategies.

For some categories of child death such as those deaths related to birth defects, childhood diseases or physical vulnerabilities (natural deaths), prevention advice may belong better in the hands of public health or medical science. But other child deaths, such as accidental or unintentional deaths, may be appropriate for us to explore. In FY 2002, 10 of 97 child deaths reviewed by our office were because of fire, accounting for 21.3% of the non-natural deaths reviewed. In FY 2001, fires accounted for 10% of child non-natural deaths and in FY 2000 fires accounted for 9.6 % of the child non-natural deaths.

Fire is the number one leading cause of unintentional death for children under the age of five in Illinois. In two-thirds of residential fires in which a child is injured or killed a working smoke detector is not present. While a child playing with fire accounts for only 5% of residential fires, it causes 40% of residential fire related deaths among children (National Safe Kids). In the majority of home fires started by children the fires begin in the bedroom or living room where the children have been left alone to play and the children begin playing with matches or lighters. Some of the families served by the Department are more prone to environmental risks of child fire fatalities. Parents with drug problems may not realize the dangers inherent with lighters and matches left around the house. They may not understand that the influences of drugs or that a sleepy recovery from a recent high compromises their capability of supervising curious five-year-olds and preschoolers. But child welfare workers should be aware of the increased risks. They need to develop realistic safety plans and secure extra precautions to counter risks while parents attempt recovery. In a recent case a worker reported the mother was not a smoker even though her continued drug use included smoking cocaine and marijuana. In this case the child playing with his mother's lighter escaped the fire; his younger brother perished. Almost two-thirds of child victims are not the children playing with the fire (National Safe Kids).

Child protection investigators, intact family workers and workers serving our foster care and independent living children need to heed lessons learned from death investigations, providing prevention education to families and assisting families in safety planning. Child welfare management should support such efforts by giving front line workers the training, supplies and equipment they need to realistically secure the safety of our children and their families. Saving one child is the first step to lowering these mortality rates.

Respectfully,

Denise Kane

Denise Kane, Ph.D.
Inspector General

INTRODUCTION

I. THE OFFICE OF THE INSPECTOR GENERAL (OIG)

The position of 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 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 the professionalism of the Department. The value and focus of the OIG is the individual life of the child.

A. INVESTIGATION CATEGORIES

1. Death and Serious Injury Investigations

The OIG investigates deaths and serious injuries of all Illinois children and families who were involved in the child welfare system within the preceding twelve months. The OIG is also a member of Child Death Review Teams around the state. The Inspector General is an ex officio member of the Child Death Review Team Executive Council. The OIG receives notification from the Illinois State Central Register (SCR) of 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. Reports are issued to the Director. The following chart summarizes the death cases reviewed in FY 03:

Child Deaths in FY 03 Meeting Criteria for Review	**122**
Preliminary Investigations Conducted	**22**
Case Records Reviewed	**77**
Full Investigative Reports Submitted to DCFS	**6***
Investigations Pending	**14**

*Some of these reports involved the deaths of multiple children.
A total of thirteen child deaths were investigated in these six reports.

Summaries of death investigations that resulted in major recommendations are included in the Investigations section of this Report. See page 48 for a summary of all child deaths reviewed by the OIG in FY 03.

2. General Investigations

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

3. Child Welfare Employee Licensure Investigations

The General Assembly mandated that the Department of Children and Family Services institute a system for licensing child welfare employees. Licensing is required for both Department and private agency child welfare and licensing workers and supervisors. The Department (Office of Employee Licensure) administers and issues employee licenses. The Office of the Inspector General of the Department of Children and Family Services investigates and prosecutes Child Welfare Employee Licensure Complaints.

Referrals for Employee Licensure Investigations are screened by a committee composed of representatives of the OIG, the Child Welfare Employee Licensure Board and the Department's Division of Employee Licensure. When an Employee Licensure Investigation is completed, the OIG, as the Department 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 with an opportunity for a hearing on the issue. An Administrative Law Judge presides over the hearing and reports findings and recommendations to the Child Welfare Employee Licensure Board. The following chart reports disposition of FY 03 investigations:

Investigations Referred in FY 03	**16**
Investigations in Abeyance*	**1**
FY 03 Investigations Closed	**13**
Investigations referred prior to FY 03 Closed	**2**
Notification of Ineligibility for Licensure	**1**
TOTAL Investigations Closed in FY 03	**16**

*This investigation was referred for possible criminal prosecution. At the request of law enforcement, further investigation was put on hold pending the criminal investigation.

Of the investigations closed in FY 03, the following chart summarizes the results:

Recommendations for No Licensure Action	**5**
Recommendations for Non-issuance of License	**2**
Recommendations for Hearing on Licensure Action	**7**
Technical Assistance for Application Evaluation	**1**
Employees Resigning or Retiring during Investigation	**1**

4. Criminal Background Investigations and Law Enforcement Liaison

The OIG provides technical assistance to the Department and private agencies in performing criminal history checks. In FY 03, the OIG performed 9,461 searches for criminal background information from the Law Enforcement Agencies Database System (LEADS). In addition, in the course of an investigation, if evidence indicates that a criminal act may have been committed, the OIG may notify the Illinois State Police, Attorney General or other appropriate law enforcement agency or elect to investigate the alleged act for administrative action only. The OIG assists enforcement agencies with gathering necessary documents. If a law enforcement agency elects to investigate, the OIG will put on hold that portion of the OIG investigation and retain the case on monitor status. If a law enforcement agency declines to prosecute, the OIG will determine if administrative action is appropriate.

B. ADDITIONAL RESPONSIBILITIES

1. Department of Children and Family Services OIG Hotline

Pursuant to statute, the OIG operates a statewide, toll-free telephone number for public access. This past year, the General Assembly clarified through legislation that the OIG Hotline is available to all members of the general public. 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 supervisors ranging from breaches of confidentiality to general incompetence;
- Complaints about private agencies or contractors;
- Child Abuse Hotline information;
- Child support information;
- Foster parent board payments;
- Youth College Fund payments;
- Problems accessing medical cards;
- Licensing questions; and
- General questions about DCFS and the OIG.

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

The following chart summarizes the response to calls received in FY 03:

Information and Referral	**963**
Referred to SCR Hotline	**376**
Request for OIG Investigation	**109**
TOTAL Calls	**1448**

2. Ethics Officer

The Inspector General is the designated 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 03, 351 Statements of Economic Interest were submitted to the Ethics Officer. Of the 351 submitted, 39 indicated potential conflicts of interest. The 39 were further reviewed and 7 required further clarification from the employee. Twenty-six 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.

Economic Interest Statements Filed	**351**
Statements Indicating Possible Conflicts	**39**
Statements Requiring Clarification	**7**
Advisory Letters Sent to Employees	**26**

3. Consultation

OIG staff provided consultation to the child welfare system through review and comment on proposed rule changes and through participation on various ethics and child welfare task forces.

4. Best Practice Initiatives

Informed by OIG investigations and practice research, the OIG's Best Practice Project assists 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 tests of strategies. The initiatives are evaluated to ensure the use of evidence based practice and determine the effectiveness of the model. See page 151 of this Report for a full discussion of the current initiatives.

II. OIG INVESTIGATIVE PROCESS

The OIG investigative process begins with a Request for Investigation or when the State Central Register notifies the OIG of a child's death or serious injury. In FY 03, the OIG received 2119 Requests for Investigation. Requests for Investigation and notices of deaths or serious injury are screened to determine whether the facts suggest possible misconduct by a Department employee, private agency employee or foster parent, or whether there is the need for systemic change. If an allegation is accepted for investigation, the OIG will review records and interview relevant witnesses. The OIG reports to the Director of the Department and the Governor, with recommendations for discipline, systemic change, or sanctions against private agencies. The OIG monitors the implementation of accepted recommendations. The OIG may work directly with a private agency and its board of directors to ensure implementation, when recommendations are regarding 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 be put on "hold" or that an employee be placed on "desk duty" pending the outcome of the investigation.

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

A. INVESTIGATIVE PROCEDURES

1. Administrative Rules for the Office of the Inspector General

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 relevant to employee licensure action. The Rules also address the Inspector General's Reports to the Director.

2. Confidentiality

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

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

3. Impounding

The OIG is charged with investigating misconduct "in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution." To conduct thorough investigations, investigators may impound files to ensure the integrity of records. 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.

B. OIG REPORTS

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

When recommendations concern a private agency, appropriate sections of the Report are submitted to the agency director and the board of directors. The agency may submit a response to address any factual inaccuracies in the Report. In addition, the board and executive director are given an opportunity to meet with the Inspector General to discuss the Report and recommendations.

The OIG uses some reports as teaching/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.

III. RECOMMENDATIONS

In its reports, the OIG makes recommendations for systemic reform and 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.

Once a recommendation regarding discipline has been made, the OIG will present it to the Director of the Department and/or to the Director and Board of the private agency. The OIG monitors implementation of recommendations for disciplinary action. In addition, the OIG will determine whether the facts suggest a systemic problem or an isolated instance of misconduct or bad practice. If the facts suggest a systemic problem, the OIG may investigate further to determine appropriate recommendations for systemic reform.

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

The OIG monitors implementation of OIG recommendations. Monitoring may take several forms. The OIG may monitor to ensure that Department or private agency staff implements the recommendations or may work directly with the Department or private agency to implement recommendations that call for systemic reform. The OIG may "incubate" accepted reform initiatives for future integration into the Department.

SYSTEMIC RECOMMENDATIONS

OIG investigative reports include both systemic and case specific recommendations. The systemic reform recommendations have been categorized below to allow for analysis of the recommendations according to the function of the child welfare system that the recommendation is designed to strengthen. The OIG is a small office in relation to the child welfare system. Rather than address problems in isolation, the OIG views its mandate as strengthening the ability of the Department and private agencies to perform their duties.

CHILD ABUSE AND NEGLECT INVESTIGATIONS

Violence

- The Department must train child protection investigators about the rights of child victims of violent crimes; providing effective linkage to the State's Attorney's Witness Victim Unit; and assisting the child and family in accessing the Attorney General's Crime Victims Compensation Program, which assists the victim with medical and hospital expenses, or other service expenses not covered by insurance. The child protection investigator should accompany the child victim and non-offending parent/caretaker to his/her first appointment with the State's Attorney's Witness Victim Unit to ensure that both jurisdictions (criminal and child protection) safeguard the best interest of the child. When a conflict exists between the parent's desire to remain in a domestic violence situation and the child's need for protection, the investigator should contact the Department's Legal Services, who can request that a guardian *ad litem* be appointed for the child in domestic relations court.

- Child protection procedures requiring investigators to seek court orders when the alleged child victim of abuse or neglect cannot be located should be redrafted to coincide with the State's Attorney's criteria for case screening: a) when the investigator has exhausted all diligent efforts to establish contact; and b) when there is an identifiable risk of serious harm to the child.

Investigatory Procedures

- Child protection trainings must emphasize objective investigative practices including, but not limited to: (a) basics of fact-finding interviews, including the who, what, where, when, why, and how of the incident; construction of a 24 to 72 hour time line of events leading up to the incident; and verification of information provided; (b) basics of a thorough scene investigation, including documentation of observations, measurements and the caregiver's description of the incident using appropriate props (such as a lifelike doll) in the environment where the incident occurred; and (c) collaborative logical analysis of information (scene investigation, interviews, and physical examination of the child) with medical personnel and law enforcement involved in investigation.

- Child protection administrators and supervisors must ensure that child protection investigators obtain necessary medical and police documents for a thorough investigation.

- Although the Illinois legislature has provided that the Department's investigatory powers include the ability to subpoena documents [20 ILCS 505/21], and Department Procedures 300, Section 300.60(h) provide instructions for issuing administrative subpoenas, the practice is seldom used. The Department should immediately issue a policy directive and/or institute remedial training to address the use of administrative subpoenas during investigations.

- Child protection procedures should be amended to correctly reflect the index of water temperatures and corresponding exposure times at which a scald will occur for infants and children. Investigators must be required to hold an approved thermometer in the stream of hot water until the temperature stops rising and record the amount of time that elapsed from turning on the water until the temperature stopped rising. If a family refuses to allow the investigator to test the water, the investigator should solicit the help of law enforcement (when they are also investigating the incident), building management or the local building department for access to the hot water heater.

- Child protection procedures should require investigators to collect and document information on the alleged perpetrator's access to children, current employment, and family resources and income.

- The Department should issue an immediate memorandum to all child welfare administrators to stop assigning child protection investigations to reporters who observed the abuse or neglect outside of their professional duties.

- Child protection investigators and supervisors should be reminded of the importance of updating information in the SACWIS database system before abuse and neglect reports are finalized.

Home Safety

- In child protection investigations involving families with infants, investigators should ensure that every infant has its own crib or bassinet with a firm mattress. An infant without a crib or bassinet with a firm mattress indicates an unsafe factor on the CERAP. The worker must educate the family about sleep safety, using brochures, discussion, video and/or demonstration. Further, child protection investigators should help families obtain a crib. Any time an infant is placed in a home via a CERAP safety plan, the child protection investigator must ensure there is a crib in the home, and the investigator must educate the family.

Undetermined Finding

- The OIG reiterates its prior recommendation that the Department replicate the practice wisdom of Medical Examiner's Offices and develop procedures for use of an "undetermined" child protection investigation final finding.

LEADS

- The Department should amend the LEADS protocol to eliminate the restrictions to age and disability in allegations for "cuts, welts, and bruises". Verification of whether the caretaker has a violent criminal history is critical regardless of the age of the child.

- Department Rules should be amended to require a criminal history check, in addition to a CANTS (child abuse) check prior to approval of employment-related childcare for our wards.

Hotline

- The State Central Register (SCR) protocol should be amended to instruct the hotline operator to contact the police immediately when a caller alleges that a driver may be intoxicated and driving erratically.

- The State Central Register (SCR) should be instructed that a hotline call involving any Department employee including clerical staff must be sent to a county other than where the employee works for both meeting the mandate and the full investigation.

INTACT FAMILY SERVICES

Substance Abuse

- Mothers with substance exposed infants who are referred to intact family services must receive intensive specialized intact families services that are designed to safeguard children from harm while providing effective substance abuse treatment.

- The Department should review all intact cases where a mother has given birth to a third substance exposed infant to determine if an order of protection is necessary to ensure that the parent(s) are complying with treatment.

- In 1998, the OIG recommended that drug screens in intact family cases include the use of breathalyzers to test for alcohol in cases where the caretaker is a severe alcoholic. The OIG reaffirms this recommendation in light of an investigation in which a guardian, accompanied by her grandniece and grandnephew, collapsed with a blood alcohol level of .405 while attempting to board a bus. Each child protection office should have a breathalyzer (cost $350) available and an intact family worker trained to administer it.

- If urine drops are used in conjunction with breathalyzers, there should never be more than 12 hours notice before a drug drop as alcohol passes through the system faster than drugs. In addition, the days and times of alcohol tests must vary so that clients are not able to predict them.

Home and Child Safety

- Many children die or are injured as a result of fires that could be prevented through appropriate safety measures. The OIG has developed an educational home safety checklist that identifies safety concerns, including the presence of a functioning smoke detector. This educational tool should be used by intact family workers when the case is first opened, when a parent moves to another home, and when the case is closed.

- The Department should reduce environmental risks to children by: (a) requiring private agency intact family programs to use of the home safety checklist and prevention education, and (b) incorporating the home safety checklist into the Child Endangerment and Risk Assessment Protocol (CERAP) process.

- The Department and private agencies should make portable cribs (e.g., Pack and Plays, estimated cost $59-79) or similar products approved by the Consumer Product Safety Commission available to families on an emergency basis.

- The Department should initiate a safety campaign to address home safety, including sleep safety. The videotape, "The Hazards and Risk Factors of Co-Sleeping and Bed Sharing," public service safety videos, and other free printed materials should be made available to workers to help them understand the importance of reducing environmental risks.

Norman Funds

- To reduce fraud within the Norman Fund Program, private agency requests for Norman funds should come from an authorized designee in the business or administrative office of the agency. The authorized designee would be responsible for an internal control system of requests.

General

- The Department must ensure that intact case managers are visiting families on a weekly basis.

- Intact Family Services workers and supervisors must be retrained in the Department's paramour policy and LEADS protocol. Training should emphasize the importance of conducting criminal background checks and assessing arrest information whenever there is a risk of violence in the home.

MISSING AND RUNAWAY CHILDREN

- The Department's procedures on Missing and Run Away Children should be revised. To ensure the fastest possible response time from law enforcement and child welfare professionals, OIG recommended changes in the current DCFS missing child procedures (329) to require *caregivers to notify the police* in instances when children are missing or foul play is suspected. Caregivers are then required to notify caseworkers or the DCFS Runaway Hotline. Caseworkers are required to provide the police with follow-up information, notify the National Center for Missing and Exploited Children, notify the parent(s) or guardian of the child, the child's Guardian *ad litem*, Juvenile Court, and file an Unusual Incident Report. The caseworker is also required to make attempts to locate the child immediately and on a regular basis thereafter.

  Since a child's vulnerability varies by age and capacity, the OIG recommends alternative actions based on the circumstances of the disappearance, the child's age, and the child's vulnerability. The highest level of response is warranted for a child:
  - of any age who is *abducted*, or
  - if there is a *suspicion of foul play*, or
  - if the child is *vulnerable*, or
  - if the child is *under 14 years* of age.

  The police should also be notified if a child between 14 and 18 years of age, has not returned home within two hours after curfew. If a child over 18 years old is missing, but is not vulnerable and there is no suspicion of foul play, the caregiver should contact the caseworker and the caseworker should make attempts to locate the child immediately and regularly thereafter.

  When a runaway child is found, either by police or others, the OIG recommends alternative actions based on the child's age, frequency of run behavior, and duration of time between run episodes. Depending on the child's previous runaway behavior and other risk factors, child welfare staff should place the child, if possible, with a caregiver the child trusts and who is willing to cooperate with a family conference. The caseworker should then coordinate the appropriate team to arrange for the necessary services, including family conference, assessments, and transportation to the child's former school. The caseworker is responsible for notifying the child's parents, guardians, previous caretakers, police, and court personnel of the child's return.

- Of the 54 missing pregnant or parenting youths, 53%(29) are assigned to a run unit that is located in a south suburb. The majority of these teens' placements are located in Chicago. In order to develop better working relationships with the Chicago Police Department and other agencies needed to assist these youth, a satellite run unit should be opened in Chicago.

- In cases where the older Cook youth desires to return to a parent who has had a history of substance abuse the Department should adapt and pilot the specialized substance abuse services of the Intact Family Recovery for Family Reunification Services. The use of extended visits can allow opportunities for applied problem solving with the support of the IFR teams. In cases where the involved youth is a parent, the IFR team can assist in early childhood services and well-baby checks.

CONFLICTS OF INTEREST

- The Department should draft a conflict of interest rule similar to Rule 437 that applies to private agencies. The rule should prohibit multiple relationships and other relevant conflicts of interest within private agencies and should be accompanied by training for private agency staff on conflicts of interest issues and forums for discussing applied ethics issues. The OIG Ethics Office can provide assistance with these efforts.

MEDICAL

- The OIG previously recommended that the position of the Chief of Nursing Services be transferred and placed under the supervision of the Department's Office of the Guardian to assist with medically complex cases. This position should be responsible for ensuring that dying children in state care are referred for palliative and/or hospice services, as well as coordination and monitoring of the child's end of life care.

- In 2001, the Inspector General recommended that the Department require the use of developmentally appropriate behavioral monitoring and tracking for any child on psychotropic medications by using reporting forms similar to those used by the Illinois State Board of Education. The Guardian's Authorizing Agents should require and gather vital information from the contracting agencies prior to authorizing the approval of medications for the children in their programs. This information should include, but not be limited to: baseline weight, weight gain/loss, blood pressure, cardiac measures, and dyskinesia. Baseline information pertaining to the targeted behaviors and programming used to target the behaviors should also be obtained to ensure that medication is not used in lieu of programming. The Inspector General also recommended that the Department should require that children and adolescents on psychotropic medication be taught how to use a developmentally appropriate daily mood diary to encourage self-monitoring of their own behaviors. The Inspector General reiterates these recommendations.

- The Medication Administration Log (Form CFS 534) should be revised to include the recording of significant side effects from the ward's medication.

- The Guardian's Office's should convene a panel to examine the present population of high-risk wards, many of whom include children and youth receiving beta-blockers and multiple psychotropic medications, to recommend placement and treatment options. The panel should include the guardian, psychiatrists, psychologists, a pharmacologist, adolescent health experts, ethicists and selected independent examiners.

- The Department's Guardian, together with foster children living with life threatening illnesses and their foster parents, and if appropriate, biological parents, should develop an individual care plan that considers the age appropriate wishes of the child, the spiritual, physical and emotional needs of the child and his/her caregivers, and provides for appropriate child focused palliative and/or hospice care.

- Where permanency is being achieved for a child with a life threatening illness, the adoption or guardianship subsidy must reflect the individual care plan.

EDUCATIONAL SERVICES

- The Department's Procedure 314 Educational Services should be revised to clarify that for children placed in group homes and residential facilities, the Department worker shall: (1) communicate, at least quarterly, with the child's school, with at least one annual contact being in person; (2) read the child's Individualized Education Program (IEP) plan and familiarize oneself with the child's learning issues; (3) seek meeting dates of MDC/IEP conferences and attend the MDC/IEP conferences; and (4) notify the Illinois State Board of Education of educational surrogate parents that are unavailable or uncooperative, and/or request that a new surrogate parent be appointed.

FOSTER CARE

- When cases are transferred to another private agency, the Department's Purchase of Services Division should track child and foster home files by establishing records inventory and sign-over procedures.

FOSTER HOME LICENSING

- In cases of egregious foster home licensing violations, the Department's licensing enforcement procedures must provide for immediate licensing revocation proceedings.

- All current and future relative foster care license applicants should submit a physician-certified medical reporting form, rather than the self-report form currently being used.

- Determining foster home licensing responsibility in split cases is a clinical decision that should not be made by the Department's Central Office of Licensing. When transferring or assigning child cases, the Department first needs to identify all the children in the foster home, and assign their cases and licensing responsibilities 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 delineating the role and monitoring duties of each agency for the six-month clinical reviews.

- Foster home licensing staff should meet with all caseworkers with children in the foster home prior to the annual and monitoring home visit by the licensing worker. The purpose of the meeting is to assist the licensing worker in becoming more familiar with the home by gathering information about the home, reviewing services provided to the foster children in their care, and identifying any concerns about the home.

COURT INVOLVEMENT

- The Department should develop a statewide uniform practice in juvenile court regarding temporary custody and guardianship when the intention is to leave the children in their biological home. DCFS Legal should be asking courts to issue orders of protection in such cases rather than temporary custody and guardianship orders.

INDEPENDENT LIVING

- Wards in independent living should be required to sign a consent allowing caseworkers to contact their college or employment counselors. This requirement should be a part of the ward's subsidy agreement.

PREGNANT AND PARENTING TEENS

- The Teen Parent Service Network contract should be revised to require the agent to: (a) read the entire case record as the initial step in the comprehensive assessment process; (b) compile a viable list of the teen parent and infant/child's extended support system; (c) invite and involve the support system in a care and support plan for the young family, and in cases that may require private guardianship, arrange a mediated family conference and follow up services; and (d) obtain necessary consents from the teen parent on her/himself and on her/his non-ward child so that well baby and doctor/medical/rehabilitation records for ongoing care of the infant/child, and documentation of the parent's medical care can be secured.

- The Teen Parent Service Network must comply with Department rules that require that all wards' discharge plans be staffed, and all individuals involved in a ward's case (professionals, significant individuals in the ward's life, and extended family, if applicable) participate in the discharge staffing and the development of the discharge plan.

- The Department needs to expand the clients the Parenting Assessment Teams (PAT) evaluate to include pregnant and parenting wards who have a history of psychiatric problems or create a separate PAT to assess such teen-parenting wards

- The Teen Parent Service Network must develop a formal referral process for teens who are reluctant to continue their pregnancy or care for their infant/child.

PATERNAL INVOLVEMENT

- The Department should establish a unit to assist non-custodial fathers who are invested in their children in obtaining legal custody and/or guardianship of their children.

- Family conferences should be convened in cases where a parenting ward has a steady relationship with the infant's father and his family. This conference can be used to share home and safety information with the father and his extended family.

INTERSTATE COMPACT

- Interstate Compact procedures should be amended to ensure that workers request specific services. The Interstate Compact Office should develop a form to prompt referring workers and supervisors to identify and request services that would be required if the family were living in Illinois.

- Department procedures should be amended to provide timelines for submission of the Interstate Compact Form that is used to initiate out-of-state service provisions. The procedures must require that the case manager transmit the form to the Interstate Compact Office within 48 hours of a court-ordered placement. The Interstate Compact Office must transmit the form to the receiving state within 5 days of submission.

- The Interstate Compact Office must proactively communicate with the receiving state to ensure that services begin from the first day of placement. If the court has ordered out-of-state placement and it is impossible to ensure services from the date of placement, the court must be immediately notified of that fact.

- Case managers and supervisors must be trained and procedures must reflect that when an out-of-state placement is being considered, paperwork must be prepared in advance, and the Interstate Compact Office notified in advance of the court date.

WORKPLACE BEHAVIOR

- The Department's Computer Security Guide should be amended to clarify that egregious abuse of e-mail and the internet including threats, sexual harassment and access of child pornography sites will subject the user to immediate discipline or discharge.

This annual report covers the period of time from July 1, 2002 to June 30, 2003. The current administration of the Department was appointed in April 2003. The Inspector General appreciates that in some cases, the Department may require additional time for implementation that may not be reflected in this report. The OIG will monitor future implementation of recommendations and report back in next year's annual report.

DEATH AND SERIOUS INJURY INVESTIGATIONS

DEATH AND SERIOUS INJURY INVESTIGATION 1

ALLEGATION

A six year-old girl died after being severely beaten and left outside in the snow by her mother's boyfriend. A child protection investigation involving the family was pending at the time of the girl's death.

INVESTIGATION

The family had initially become involved with the Department four months prior to the girl's death when the mother, her boyfriend and the girl visited a state public health office. Staff at the office observed that the mother, who was pregnant, had bruises on her arms and the girl had two black eyes. When a staff member invited the girl to use coloring books in another room in an attempt to speak with her privately, the father was overheard instructing the girl in Spanish to tell anyone who asked that her black eyes were the result of a fall down stairs. The office supervisor contacted her superiors who told her not to call the police but to make a hotline call. Upon calling the hotline, the supervisor received a recorded message informing her an operator would call back. By the time an operator returned the call the family had left the public health office. Information obtained by office staff was related to the hotline and a child protection investigator was assigned to the case.

The following day, the investigator visited the address provided by public health staff but no one answered the door. The investigator left a card and information in Spanish but was not contacted by either parent. One week later, the investigator went to the girl's school and learned that although she had not attended classes yet that year there was no information suggesting she had transferred to another school. The investigator made two more unsuccessful attempts to visit the family at the address provided and also attempted to reach them by telephone and mail, to no avail. After six weeks had passed since the hotline report and the investigator had not had any contact with the family, he contacted local police to request assistance. The investigator was informed by an officer there had been a recent domestic violence call at the address by a person with the same last name as that provided by public health. The officer further stated, however, that law enforcement could not become involved unless police directly observed evidence of child abuse.

The investigator made two additional unsuccessful trips to the home prior to the 60-day deadline for closing child protection cases. When the deadline was reached, the investigator's acting supervisor instructed him to unfound the report based on the family's inaccessibility, unwillingness to cooperate and the absence of any previous abuse or neglect reports against them. In an interview with the OIG, the acting supervisor stated he was unfamiliar with the Department's provision for undetermined findings which allows investigations to continue beyond the 60-day deadline in cases where additional time is required or credible evidence of abuse cannot be attributed to an individual perpetrator. Utilizing undetermined findings enables investigators to present the facts of a case without making an unequivocal conclusion and allows for future scrutiny if information comes to light at a later date. In separate interviews with the OIG, both the investigator and his regular supervisor stated they were unaware that when a juvenile involved in a child abuse or neglect investigation cannot be located and a risk of injury exists, Department procedure requires the case to be screened into court in order to secure a child protection warrant. In her interview, the supervisor stated that in her experience, the State's Attorney's Office will not screen a case into court when the child cannot be

located.

Six days after the case was closed, police were called to the family's home to break up a fight between the boyfriend and his brother. When officers arrived the boyfriend's brother was holding a knife and the boyfriend, the mother and the girl all stated the brother was responsible for their injuries. The boyfriend had two stab wounds while the mother and daughter were bruised. The brother was arrested and the mother and her daughter were transported to the hospital for treatment. Both responding officers as well as hospital personnel contacted the hotline to report the incident and a second child protection investigator was assigned to the new investigation.

The second child protection investigator first met with the family at a hospital after the mother was admitted and delivered her second child. Both the mother and the girl stated that the boyfriend's brother was responsible for their injuries and denied the boyfriend was ever violent towards them. In her case notes, the investigator recorded the girl had symmetrical marks underneath her eyes and opined that anemia rather than physical abuse could be the cause. The mother stated she intended to attend an upcoming hearing and continue to pursue charges against the brother. The boyfriend stated that he and his brother had been drinking heavily on the night of the incident and that the fight was the result of an argument over damage to the boyfriend's car. The girl confirmed to the investigator that she was not in school, a development the boyfriend attributed to the family's frequent moves in attempts to find more affordable housing. The investigator conducted a domestic violence and substance abuse screen which denied the existence of either factor in the home.

In an interview with the OIG, the second investigator stated at the time she accepted the case she was aware a previous investigation had been unfounded because of the family's non-cooperation and that the boyfriend had been the alleged perpetrator. The investigator was also familiar with the injuries observed by the public health workers to the mother and daughter and the boyfriend's instruction to the girl to blame a fall for her black eyes. The investigator had spoken with the girl's maternal grandfather who told her the boyfriend hit the mother and the girl. The investigator claimed to the OIG she had discounted this information, however, because she believed the grandfather had been drinking. The investigator told the OIG she believed the girl was anemic because the marks under her eyes were purple and not black, even though the girl said she had been punched in the face and the hospital had recorded her blood count as normal. The investigator also stated that she did not believe it was significant the girl was not attending school because she was involved with other Hispanic families who kept their children out of school. Although Department rules require interviews with the reporters of hotline calls, the investigator never spoke with any of the three police officers called to break up the fight in the family home. The investigator said she was unable to contact them because the officers worked the overnight shift which conflicted with her schedule.

In interviews with the OIG, two of the officers stated that the boyfriend's brother said the fight in the home was the result of an argument over the boyfriend's ongoing physical abuse of the girl and that the boyfriend frequently hit both the girl and her mother. The two officers also stated they observed a child-size bite mark on the boyfriend's back at the time of the incident. The third officer, who made the call to the hotline, told the OIG he was with the mother and did not hear the statements made by the boyfriend's brother. When the officer called the hotline, he did not provide the information regarding the brother's allegations or the bite mark observed on the boyfriend. All three officers told the OIG they had not been contacted by anyone from the Department and had not received any requests for the arrest report.

Two weeks after the child protection investigator spoke with the family at the hospital following the second child's birth, she attempted to call the family but received no answer. One week later she went to the family home and found they had moved to an unknown location. At the same time, charges against the boyfriend's brother were dropped because the boyfriend and the mother had failed to appear in court to pursue the case.

Despite the fact the family was evading a second child protection investigation and had not followed through with the case against the boyfriend's brother, the investigator took no further action on the case until after the girl's death.

Two weeks after the investigator learned of the family's move, the girl was brought to a hospital emergency room with severe injuries and a core temperature of 74 degrees. She was later pronounced dead. The mother told police that she was being beaten by the boyfriend when the six year-old girl intervened. The boyfriend then hit and kicked the girl and threw her into a wall before tossing her into the snow outside the home. The girl lay unconscious in the snow for several hours before being taken to the hospital. The boyfriend was charged with murder and is currently awaiting trial.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Procedure 300 requiring investigators to seek court orders when the child cannot be located should be redrafted to coincide with the State's Attorney's criteria for case screening:

a) When the investigator has exhausted all diligent efforts to establish contact; and
b) When there is an identifiable risk of serious harm to the child.

The Department agrees. Department Rules and Procedures will be revised by March 1, 2004.

2. The Department should meet with the Chicago Police Department to identify and specify circumstances in which police can offer assistance when families cannot be found or are uncooperative.

The Department and the OIG have previously worked with the Chicago Police Department in an effort to further communication. These efforts will resume in January 2004.

3. The OIG reiterates its prior recommendation that the Department should replicate the practice wisdom of medical examiner's offices and develop Rules and Procedures for use of an "undetermined" final finding in appropriate child protection investigations.

The Department requested the OIG draft a detailed proposed plan for review.

4. The second child protection investigator should be disciplined, up to and including discharge, for failure to interview the reporter or perpetrator, investigative bias and failure to attempt to screen the case when the parents evaded the Department for the second time and continued to keep the child from school.

The second child protection investigator was given a 30-day suspension.

5. The second child protection investigator's supervisor should be disciplined for failure to administer appropriate supervision to ensure that the police were interviewed and that the investigator address investigative bias and failure to screen the case when the parents evaded the Department for the second time and continued to keep the child from school.

The second child protection investigator's supervisor was given an oral reprimand.

6. The Department should require training all child protection investigators in criminal cases when a child has been a victim of violence to arrange for services for the victim with the State's Attorney's Victim Witness Unit and the Attorney General's Crime Victims Compensation Program. The Victim Witness Unit would provide support for victims in court, including transportation, and serve as an

advocate for the victim. The child protection investigator should accompany the child victim and non-offending parent/caretaker to his/her first appointment with State's Attorney's Witness Victim Unit to ensure that both jurisdictions (criminal and child protection) safeguard the best interest of the child. Where a conflict may exist between the parent's desire to remain in a domestic violence situation and the child's need for protection, the investigator should contact the Department's Legal Division who can request that a Guardian *ad litem* be appointed for the child in domestic relations court. The Crime Victim Compensation Program would provide the victim with medical and hospital expenses, counseling by psychiatrists, clinical psychologists or certified social workers and compensation for loss of earnings or support and other losses or expenses not covered by insurance. However, the Attorney General's Compensation Program prohibits use of the funds if the adult victim continues to reside with the abuser.

The Department's Division of Legal Services will work with the OIG to develop a training.

DEATH AND SERIOUS INJURY INVESTIGATION 2

ALLEGATION

A four month-old girl suffocated after her father stuffed a cloth into her mouth to prevent her from crying. Two months prior to the baby's death, a child abuse investigation against her parents was unfounded.

INVESTIGATION

The family's initial involvement with the Department began after the girl was brought into a hospital emergency room with first- and second-degree burns to the left side of her face and torso and her left arm. Both parents stated the father had given the baby a bath in the sink and when she squirmed, the father's hand slipped and hit the hot water faucet. At the time of the incident, the mother was not present in the home. The parents told hospital staff the water in their building was extremely hot and burned the baby before the father could react. However, hospital staff found the injuries suspicious in relation to the parent's explanation and contacted the hotline. A child protection investigation was opened. Following emergency treatment, the baby was transferred to a second hospital where she remained while the investigation was pending.

The child protection investigator interviewed both parents at the family home. The parents reiterated their account in greater detail, explaining that the father had given the baby a bath to cool her off because their apartment was very hot. The parents stated the father cared for the baby almost exclusively because of the mother's health problems. The investigator recorded it was extremely warm in the apartment and that hot water coming out of the sink faucet, "felt very hot to the touch." The investigator did not use a thermometer to obtain an accurate reading of the hot water temperature. Although the parents stated other residents of the building had complained about excessively hot tap water, the investigator did not attempt to identify any of these tenants, nor did she contact building management or the local building department to verify any previous complaints. In addition, the investigator did not ask the father to demonstrate the mechanics of how the accident occurred.

Ten days after the incident, the investigator called the mother at the family home and stated she was on her way to the home with a thermometer to gauge the water temperature. The mother agreed to the visit, however when the investigator arrived one hour later there was no answer at the door. Later that same day, the investigator's supervisor went to the home to discuss housing issues. The mother gave the supervisor permission to check the hot water temperature if she wanted to but said the problem had been fixed. The supervisor did not measure the hot water temperature while she was in the home. In an interview with the OIG, the child protection investigator stated that although Department-issued thermometers were available in her field office, batteries for the thermometers had not been made available.

While conducting a family history, the investigator learned the mother had relinquished custody of a son 10 years earlier. When questioned by the investigator, the mother stated she had the child when she was 17 years-old but was unable to care for him because of her health problems and he was adopted by her grandmother. During the OIG investigation, a review of the earlier case file found the mother had been hospitalized during her pregnancy and diagnosed with serious mental illness. During her hospitalization she expressed ambivalence regarding her pregnancy and, following the child's birth, she never felt bonded with her son. The investigator also reviewed a report submitted by the second hospital's child protective services team. The report determined that, based on the child's overall good health and the parents' consistent explanation for the injury and immediate request for medical attention, the child could safely be released into her parents' custody. The child protective services team concluded its report without conducting a scene investigation or performing a skeletal survey of the baby to determine the presence of previous injuries.

Based on the information provided by the parents, local police and the second hospital's child protective services team, the investigator and her supervisor proceeded to unfound the abuse report. The supervisor

notified the second hospital the child could be released into the parents' custody. The supervisor offered to assist the parents in securing alternative housing, however, because the abuse report was unfounded, the parents were under no obligation to continue involvement with the Department and declined to participate in services. Six weeks after the investigation was closed, the father called an ambulance and reported finding his daughter lying motionless on the bed. The baby was transported to the hospital where she was pronounced dead. After providing multiple possible explanations, the father admitted to stuffing a washcloth into the baby's mouth to stop her from crying. The father stated he was tired after staying up all night and generally frustrated with the family's living arrangement and situation. After putting the washcloth in the baby's mouth, the father fell asleep unintentionally and awoke to find his daughter unresponsive. An autopsy performed by the medical examiner found numerous internal and external injuries of varying age, including bruises, burns and nine rib fractures.

Following the girl's death, an OIG investigator conducted a scene investigation and mock demonstration in the family home. Using a doll, the investigator attempted to reenact the burning incident. The OIG investigator measured the hot water temperature using a standard thermometer and found it to be 125 degrees, 5 degrees over the temperature generally regarded as safe. While the infant could have suffered burns in 125 degree water in seconds, the investigator found that the mechanism of the hot water faucet and its placement in relation to the bathroom wall made it impossible to "accidentally" turn the water on in any semblance of the manner which the parents described. An OIG review of Department policy regarding assessment of hot water in homes found a dearth of usable data and an absence of effective guidance regarding how to conduct testing in the field. A scalding temperature index provided by the Department was found to be woefully inaccurate and correct information that was provided pertained to adults, not the infants and children primarily served by the Department.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Child protection trainings should refocus on objective investigative practices including, but not limited to:
a) basics of fact-finding interviews, including the who, what, where, when, why, and how of the incident; construction of a 24 to 72 hour time line of events leading up to the incident; and verification of information provided;
b) basics of a thorough scene investigation, including documentation of observations and measurements and mock demonstration (reenactment) by caregiver(s) of the incident using appropriate props (such as a lifelike doll) in the environment where the incident occurred; and
c) collaborative logical analysis of information (scene investigation, interviews, and physical examination of the child) with medical personnel and law enforcement involved in the investigation.

The Division of Clinical Services and Professional Development will incorporate this report into child protection training.

2. Procedures 300, Section 300.50(j) should be amended to correctly reflect the index of water temperatures and corresponding exposure times at which a scald will occur for infants and children as compared to adults. Investigators must be required to hold an approved thermometer in the stream of hot water until the temperature stops rising and record the amount of time that elapsed from turning on the water until the temperature stopped rising. If a family refuses to allow the investigator to test the water, the investigator should solicit the help of law enforcement (when they are also investigating the incident), building management or the local building department for access to the hot water heater. These procedures should be cross-referenced with Procedures 300, Appendix B, Burns.

The Division of Clinical Services and Professional Development will amend policy to incorporate this recommendation.

3. Although the Illinois legislature has provided that the Department's investigative powers include the ability to subpoena documents [20 ILCS 505/21], and Department Procedures 300.60(h) provides instructions for issuing administrative subpoenas, the practice is seldom used. The Department should immediately issue a policy directive and/or institute remedial training to address the use of administrative subpoenas during investigations.

The Department agrees. An information transmittal will be issued to all child protection staff in order to remind staff of their ability to use administrative subpoenas during the course of child protection investigations. The transmittal will clearly state that if a mandated reporter who is believed to have information about the subject of a report is not allowed or refuses to speak with or provide documents to a child protection investigator, an administrative subpoena may be issued. In addition, if a parent or guardian or an alleged perpetrator refuses to meet with or speak to a child protection investigator, a subpoena may be issued.

4. This report should be used as a training tool for child protection investigations.

The report will be used in training.

5. The OIG requests permission to share this report with the head of the second hospital's child protective services team.

The Department agrees. The OIG shared the report.

DEATH AND SERIOUS INJURY INVESTIGATION 3

ALLEGATION

A one year-old boy and his mother died as a result of a fire in their home. The family had been involved with the Department and their case was closed two months prior to the fire.

INVESTIGATION

The family initially became involved seven years earlier when the mother's fourth child tested positive for opiates at birth. An intact family case was opened and a caseworker was assigned to provide services. After a period of non-compliance the mother began participating in substance abuse counseling. Although the mother repeatedly tested positive for opiates and other drugs while she was involved with the program, her case with the Department was closed after two and one-half years. In an interview with the OIG, the mother's former caseworker stated she was certain the mother had completed drug treatment as that would have been a prerequisite for case closure. The OIG was unable to locate documentation showing the mother successfully completed drug treatment. Records obtained from the drug treatment agency showed the mother continued in treatment for over a year after the case was closed before being discharged from the program. The records do not provide a reason for the discharge.

Eight months after the mother's discharge from the treatment program she was indicated for risk of harm after her youngest son, who later died in the fire, was born exhibiting symptoms of withdrawal. A second caseworker was assigned to provide intact services to the family. Again the mother was initially non-compliant and had infrequent contact with the caseworker over a period of several months. The mother eventually contacted the caseworker and expressed her desire to enter in-patient rehabilitation. The caseworker referred the mother to a program that would allow her children to live with her. Three weeks later, the caseworker's supervisor received information from the aunt of two of the mother's children that the mother had not entered the treatment program and that her children were living with various relatives. The following day the aunt contacted the supervisor again and told her the mother had taken her children to her own residence. The aunt also stated the mother was abusing substances and that one of the children had complained of being touched inappropriately by an adult male in the mother's home. The aunt provided the supervisor with the address of the mother's residence.

An OIG review of the case file found no indication either the supervisor or the caseworker called the hotline to forward this information. There was no documented evidence of any attempted contact with the mother for four months following the aunt's phone call. In an interview with the OIG, the supervisor stated she was unsure whether the new caseworker that had assumed responsibility for the case had visited the mother during that time. The new caseworker eventually visited the mother in her home and observed four of her six children. The mother told the caseworker she had completed another treatment program through the same agency and achieved sobriety. The caseworker did not attempt to corroborate the mother's claims. There was no record of the mother's involvement with the drug treatment program after her discharge two years earlier.

Although the caseworker's supervisor instructed her to confirm the mother's completion of treatment and ensure that she submit to a drug test, the OIG found no evidence to suggest either occurred. The supervisor ultimately closed the family case despite the fact the Department had only reestablished contact with the mother for two months following a four month period when the whereabouts of the mother and her children were unknown. A closing summary signed by both the caseworker and the supervisor stated that although the mother had not provided proof of compliance with services, the children appeared to be safe. In an interview with the OIG, the supervisor acknowledged she had not provided adequate supervision of the family case and cited a number of personal problems that occurred during that period of time as the cause for her substandard effort. The supervisor admitted closing the case without verifying the mother had completed drug treatment.

Two months after the case was closed, one of the children was playing with matches in the home and started a

fire. The mother was asleep at the time the fire broke out. The local fire department responded to the scene and rescued two children but were unable to save the mother or her one year-old son. The fire department reported there were no smoke detectors in the home, although that contention was contradicted by later media reports. During the caseworker's visits she limited her observations to the children's physical condition and did not conduct an assessment of the safety of the home. Such an assessment could have identified the absence of smoke detectors and other potential environmental dangers as risk factors to address with the mother. The minimal assistance and intervention provided to a family headed by a recidivist drug user with six young children failed to meet Department standards for adequate case management.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Mothers with substance exposed infants who are referred to intact family services must receive intensive specialized intact family services designed to safeguard children from harm while providing effective substance abuse treatment.

The Department is in the process of reviewing the substance affected families policy for possible revision to include specialized intact services for families with substance abuse issues.

2. The Department should review all intact cases where a mother has given birth to a third substance exposed infant to determine whether workers should obtain orders of protection to ensure that the parents are complying with treatment.

The Department is in the process of reviewing the substance affected families policy for possible revision. this recommendation will be considered in this review.

3. Many children die or are injured as a result of fires which could be prevented through appropriate safety measures. It is unclear whether there was a functioning smoke detector in the family's apartment when the case was closed. However, if the worker had completed a home safety check with the mother before she closed the case, this tragedy might have been averted. The OIG has developed a home safety checklist that is being used in the Intact Family Recovery project. Included in the list of safety items to check is that the home has a functioning smoke detector. The Department should require the use of this safety tool for use by intact family workers. This educational tool should be used when the case is first opened, when a parent moves to another home, and when the case is closed.

The home safety checklist is currently in the process of becoming part of Department Rules and Procedures.

4. All Cook County child protection investigation managers must attend the Fire and Home Safety training offered by the OIG.

The identified staff have attended the training.

5. The supervisor is currently employed by a private agency as the director of foster care. This report should be shared with the private agency.

The Department agreed. The OIG shared the report.

6. The Department should conduct a record review to insure that intact case managers are complying with the current expectation that families are visited on a weekly basis.

The Deputy Director for the Division of Child Protection will provide the results of the record review by February 1, 2004.

DEATH AND SERIOUS INJURY INVESTIGATION 4

ALLEGATION

A two year-old girl died as a result of multiple blunt trauma injuries and drowning. The girl's mother and the mother's boyfriend were charged with murder. The mother had been a Department ward whose case was closed 15 months prior to the girl's death.

INVESTIGATION

The girl's mother was the oldest of seven children whose family had become involved with the Department nine years earlier because of their caretaker's continuous substance abuse and inability to provide adequate care and supervision. After the maternal grandmother refused to pick-up the then 16 year-old mother upon her discharge from a hospital psychiatric ward, the Department assumed custody of all seven children. The mother attempted suicide several times, had a significant mental health history and compromised functioning that created a risk to her child. The girl was placed in a residential facility.

The mother was engaged in a volatile, long-term relationship with the man who fathered her first child, a boy born two years before the girl. Towards the end of her pregnancy, the mother reported to her social worker she felt an unmanageable amount of stress and a lack of support from family and friends. The mother also reported an ongoing dependence on drugs and alcohol which further eroded her ability to function. Although a drug treatment evaluation recommended intensive intervention, an OIG review of the case record found no indication the mother ever entered or completed a drug treatment program. Another evaluation completed by an adolescent outpatient treatment program recommended the mother be referred to a program for pregnant and parenting teens with an emphasis on emotional support and parent skills training. Instead, the private agency handling her case placed the mother in a supervised independent living program three weeks after she gave birth to her first child.

Eight months later, private agency staff learned the mother had become pregnant again. Because of the pregnancy, the mother had stopped taking her prescribed psychotropic medications. The mother informed staff she intended to terminate the pregnancy because she, "wasn't up to the baby thing," however the mother ultimately gave birth to the girl. Although the mother's boyfriend (the boy's father) was not the girl's father, he developed a relationship with the child and provided some financial support. The boy's father had assumed physical custody of the boy, however the mother, who still retained parental rights, frequently took the boy for overnight visits.

One year later, private agency staff attempted to refer the mother to other agencies for services in anticipation of her twenty-first birthday, at which time her case with the Department would be closed. At the time the mother's case was closed she was jobless and homeless. She was non-compliant with her medication program and unable to adequately care for her two children. The mother did not attend her case closing hearing, however the father of her first child and her sister were present in court. The father desired to assume sole custody of his son and would take custody of the girl as well. The court did not consider the change of custody issue.

Nine months after the mother's case was closed she gave birth to her third child. The mother was living with the third child's father, her new boyfriend. The boyfriend had an extensive criminal history including convictions for aggravated battery, burglary and manufacture/delivery of a controlled substance. Four months after the third child was born, the mother and the boyfriend were arrested and each charged with six counts of murder and three counts of aggravated battery to a child in connection with the two year-old girl's death.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should expand the clients the Parenting Assessment Teams evaluate to include pregnant and parenting wards who have a history of psychiatric problems or create a

separate PAT to assess such teen-parenting wards. The OIG made a similar recommendation in OIG #973,604, June 2000.

The Department agrees. A number of pregnant and parenting wards are currently being referred to Parenting Assessment Teams. The pregnant and parenting teen coordinators will remind providers of the need to refer these cases to PAT.

2. The Department should establish a unit to assist non-custodial fathers interested in their children in obtaining legal custody and/or guardianship. (See OIG #971,918)

Following the Department's federal reviews, the Department will be obligated federally to satisfy criteria related to non-custodial parents. The Department will provide a program implementation plan by March 31, 2004.

DEATH AND SERIOUS INJURY INVESTIGATION 5

ALLEGATION

A two year-old boy died of suffocation after his mother covered him with a mattress to quiet his crying. The boy's mother had been a Department ward until three weeks prior to the child's death.

INVESTIGATION

The mother had been involved with the Department since she was four years-old when she and her two siblings were removed from their mother's care. The three siblings were adopted by a couple they had lived with in foster care, however following the adoptive father's accidental death, the mother, then age 11, began exhibiting defiant and aggressive behavior both at school and in her home. After repeated incidents and arrests, the adoptive mother determined she could not control the girl and terminated her parental rights. The girl was returned to Department custody and placed in a residential facility.

Following her return to Department custody, the mother attempted suicide. Her behavior, at times, suggested severe depression and she exhibited high levels of social maladjustment and anger. Evaluators identified previous sexual abuse, gang involvement and enduring support system and trust issues as stressors that exacerbated her negative behavior. The mother's behavior stabilized in the residential facility and she was transferred to a group home. The mother continued to exhibit improved behavior, graduated from high school and began college courses. However the mother's behavior regressed as her 18th birthday approached and she subsequently dropped out of classes, ran away from the group home and began residing with a family friend whose home local police identified as a drug house. The mother was picked up by police after fleeing an altercation with the family friend at the home and underwent a medical examination which found that in addition to having a thyroid condition she was pregnant.

The mother renewed her involvement with services through a private agency program designed to work with pregnant and parenting wards. The mother's case was assigned to a recently hired caseworker with little experience in the field of child welfare. The caseworker's supervisor was also new to the agency at the time the case was assigned. An OIG review of the case record found significant gaps in documentation of contacts between the caseworker and the mother as well as extended periods during which the supervisor neglected to discuss the case with the worker. A second private agency was also involved in providing services to the mother, however the agency failed to develop a comprehensive plan for addressing the mother's myriad health and emotional issues or to ensure interaction between agency personnel involved with the case.

Following the baby's birth, staff from the second private agency noted the mother lacked appropriate parenting skills and seemed disinterested in maintaining an adequate level of care for herself or her infant. The mother told a therapist she felt overwhelmed as a new parent and felt stress as a result of her tumultuous relationship with the baby's father, an alleged gang member, and her renewed contact with her biological mother. Staff from the second private agency continued to document the mother's non-compliance with services and failure to attend appointments with physicians and therapists for herself or her son. On one occasion the caseworker from the first private agency made an unannounced visit to the group home and found the mother had left her ill baby in the care of a girl she estimated to be seven or eight years of age. In an interview with the OIG, the caseworker stated she allowed the infant to remain in the child's custody because she personally didn't feel comfortable holding children and did not intend to "babysit" until the mother returned. Despite the mother's persistent difficulties, neither involved private agency made a concerted effort to engage her in services or enlist the assistance of her adoptive mother, who frequently cared for the baby, or other potential sources of support.

Eight months after the baby was born, the mother's adoptive mother died. Following this event, involved professionals noted an almost debilitating depression and further deterioration of her behavior and compliance

with services. Staff from the second private agency, which was responsible for attending to the mother's housing needs, threatened to move her into a more restrictive group home. However, after the placement of another client into a private apartment fell through, the mother was allowed to assume the placement. No one from the second private agency was able to provide an explanation as to how the decision was reached. A family support specialist had been assigned to the case through the second private agency. The specialist had minimal contact with the mother. In an interview with the OIG, the family support specialist stated she had not been closely involved in the case because she was under the impression the mother was receiving parenting services through another program operated by the agency. An OIG review of the case record found the family support specialist rarely saw the family and at one point went six months without contact contrary to Department Rule requiring monthly visits. In her own interview with the OIG, the family support specialist's supervisor stated that although she met with the specialist every two weeks to discuss cases, she was unaware the specialist had not been meeting with the family.

As the mother's 21st birthday approached, signifying her emancipation from the Department, involved child welfare and metal health professionals documented her increasing levels of stress and anxiety. The mother's therapist noted the mother had reported self-destructive thoughts. The therapist closed the case because the mother had not attended sessions in five months. In preparation for emancipation, the caseworker from the first private agency completed a service plan which reported the mother had made satisfactory progress towards her goal of independence despite the fact she was unemployed, had made no arrangements for new housing, had failed to provide documentation of her son's medical care and was non-compliant with services. In an interview with the OIG, the caseworker from the first agency acknowledged that while the mother required additional counseling, "she didn't want to go." The mother's case with the Department was closed on her 21st birthday, however staff from the second private agency allowed her to remain in her apartment until she could move into the home of another family friend.

On the day the mother was to move, three weeks after the case was closed, she encountered logistical and scheduling difficulties. Various plans for transportation and child care failed to materialize and the mother and her son were alone at their apartment. The mother later told police she had become frustrated with the moving situation and when the boy started crying she began striking him. She then pushed a mattress and box spring on top of him and left the apartment to make phone calls to secure a ride to the new residence. Upon returning to the apartment the mother found the boy unresponsive and took him to a hospital emergency room where he was pronounced dead. The mother was charged with first-degree murder and is currently awaiting trial.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

The First Private Agency

1. The Teen Parent Service Network contract should be revised to require the first private agency and their subcontracted agencies to: a) read the entire case record as the initial step in the comprehensive assessment process; b) compile a viable list of the teen parent and infant/child's extended support system; c) invite and involve the support system in a care and support plan for the young family, and in cases that may require private guardianship, arrange a mediated family conference and follow up services; d) obtain necessary consents from the teen parent on her/himself and on her/his non-ward child so that well baby and doctor/medical/rehabilitation records for ongoing care of the infant/child, and documentation of the parent's medical care can be secured (See TPSN report, OIG #020288 et. al., March 1, 2002).

The Department is currently in the process of revising contracts with the private agency's Teen Parent Service Network. These recommendations will be included in those revisions.

2. The Teen Parent Service Network should a) amend their procedures in accordance with Rule

315.310, to require that all wards' discharge plans be staffed, and all individuals involved in the ward's case (professionals, significant individuals in the ward's life, and extended family, if applicable) participate in the discharge staffing and the development of the discharge plan; b) develop a formal referral process for teens who are reluctant to continue their pregnancy or care for their infant/ child. (See OIG report #020354, February 14, 2002).

The Department agrees to require the Teen Parent Service Network to amend their procedures accordingly. In response to Part B, the Department agrees to develop referral links to agencies that provide a full range of options as may be appropriate with the ward's culture.

3. The first private agency caseworker should be disciplined in accordance with the agency's personnel procedures for failing to call the hotline and leaving an ill infant to the care of an eight year-old child, failing to document the incident in a Unusual Incident Report, and presenting misinformation in three service plans.

The Department agrees. The OIG shared the report with the agency and the Inspector General met with agency management and a member of the Board of Directors to discuss the report. The caseworker was disciplined and has since resigned from the agency.

4. The caseworker's supervisor should be disciplined up to and including discharge in accordance with the agency's personnel procedures for inadequately supervising an inexperienced worker and failing to direct the caseworker to submit a special needs request to TPSN Clinical or schedule a multidisciplinary staffing.

The supervisor was transferred to a non-direct supervisory position.

5. The family support specialist's supervisor should be counseled for failing to monitor or supervise the family support specialist's monthly contacts with the boy.

The supervisor was counseled.

6. The family support specialist should be counseled for failing to have monthly contact with the boy and failing to document the problems with the boy's care.

The worker is no longer employed by the agency.

The Second Private Agency

7. The second private agency should ensure that: (1) any ward with a serious mental health diagnosis or any ward receiving psychotropic medication have an annual comprehensive medical examination; (2) the comprehensive medical exam and all necessary medical records be reviewed by the psychiatrist for a baseline treatment plan; (3) reliable observations of client's everyday functioning are communicated to the treating psychiatrist prior to the client's appointment; and (4) the delivery of supportive services occurs, including transporting and accompanying the client as needed to maintain appropriate treatment and follow up recommendations.

The Department agrees. The OIG shared the report with the private agency and the Inspector General met with agency mangement and a member of the Board of Directors to discuss the report. The following actions have been taken in response to the recommendations: (1) The agency has established a Nurse Practitioner Clinic to provide physical examinations at intake, annual physicals, and other medical services as needed. (2) and (3) The agency has implemented a system for coordinating the communication of medical information

and records to the consulting psychiatrist and relaying information from the psychiatrist back to program staff. The agency is evaluating also current protocol for obtaining prior medical records. (4) The program already provides or arranges for transportation. The agency will examine supporting improved connections with medical services to ensure follow-up.

8. A redacted version of this report should be used as a training tool with both private agencies to create a process of initial and quarterly multidisciplinary staffings for quality services for mentally ill pregnant/ parenting teens.

The OIG shared the report. The agencies are using this case and report in training and have begun quarterly staffings.

Hill Class Attorney

9. This report should be shared with the Hill Class attorney for assistance in developing remedies to address the misperceptions in the field regarding Hill Class members, and other issues discussed in this report.

The Department's Division of Legal Services will develop training to address misperceptions in the field related to the Hill Class Action.

OIG Response: Violence among pregnant and parenting teen wards, their families, and within their communities is a growing concern of the Department and the OIG. In response to this concern the Department's Deputy Direct or of Service Intervention, the Hill Class Attorney, and the Director of the City of Chicago's Office of Violence Prevention are collaborating to establish a community approach to address and support the reduction of violence prevalent amongst teen parents, their families, and their communities. The Office of the Inspector General continues to assist the Department in its to efforts to reduce violence among teens and their families.

DEATH AND SERIOUS INJURY INVESTIGATION 6

ALLEGATION

A one and a half year-old boy died as a result of injuries inflicted by an 18 year-old male Department ward. The ward and his 17 year-old girlfriend, also a Department ward and the baby's sister, were on run from a residential facility. At the time of the baby's death, both wards were residing in the home of the baby's foster mother, the 17 year-old girl's grandmother.

INVESTIGATION

The 18 year-old boyfriend had been a Department ward since he and his four siblings were removed from their mother's custody when he was 5 years old. Over the ensuing 8 years the boy resided in a number of relative and non-relative homes, however his ongoing behavioral problems eventually resulted in his placement in a residential facility at age 14. The 17 year-old girl had been involved with the Department since she was four years-old as a result of her mother's chronic substance abuse. At age 13 the girl and three of her siblings were placed in a non-relative foster home, however the girl refused to comply with rules established at home or in school and demonstrated extremely aggressive behavior including arrests for assault, battery and weapons possession. After being placed on house arrest as a result of pulling a knife on a classmate's parent, the girl was found to be in violation of her probation for habitually skipping school and was taken into custody by her probation officer.

Authorities identified electronic monitoring of the girl as a method of restricting her movement, however the foster mother objected to the loss of her residential phone line that would be required to operate the monitoring unit in the home. An OIG review of the case record found no indication the girl's caseworker made any attempt to secure funds to allow for the installation of a second phone line to accommodate the monitoring unit. As a result the girl was removed from the home and placed in a juvenile detention center for 16 days. Following her return to the foster home the girl's persistent, problematic behavior ultimately resulted in her placement at the residential facility. The foster mother subsequently adopted the girl's three siblings and moved the family to another state.

Following her placement at the facility, the girl improved significantly and began attending regular classes at the local high school. Although the girl's stay was not without incident, she exhibited relatively good behavior and performed well in school. She was permitted to leave the facility to visit her siblings and former foster mother in the other state as well as relatives who resided locally. On one occasion the girl was allowed to leave for a four-day visit to her aunt's home, however she did not return to the residential facility. Three days after the girl was expected back, the 18 year-old boy left on an overnight pass to visit his grandmother who lived in the same town as the girl's aunt. The boy also failed to return to the facility. Both wards were reported as being "on run" by the facility and staff contacted child welfare professionals involved with each ward.

Although the girl's caseworker contacted local police, jails and public aid in an attempt to locate her, he never attempted to speak with the girl's aunt, whom she had left the facility to visit, or any of her other known friends, relatives or previous caregivers as required by the Department's Runaway Protocol. In an interview with the OIG, the caseworker's supervisor stated that although she had instructed the caseworker to follow the protocol, she did not ensure he had done so.

The boy's caseworker also failed to contact family members in order to find him. The caseworker did not contact the boy's grandmother, whom he had left the facility to visit, until he had been missing for one month. The first time the caseworker spoke to the boy's grandmother was the morning before the boy was arrested and charged with killing the baby, his girlfriend's younger brother. The boy's caseworker has since retired from the Department.

The child protection investigation into the baby's death found the girl had been living in the home for

approximately one month prior to her younger brother's death and that her boyfriend frequently stayed in the home. The boyfriend is currently awaiting trial.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue disciplinary action against the girl's caseworker for failing to comply with Department Rule 329.30, which states that caseworkers attempting to locate lost or runaway children should contact relatives, and past known caregivers.

The caseworker was given a three-day suspension.

2. The girl's caseworker's supervisor should review this report with her administrator to enhance proactive supervisory skills.

The report was shared with the supervisor.

3. The boy's caseworker's former supervisor should review this report with her administrator toward enhancing proactive supervisory skills.

The report was shared with the former supervisor.

4. The Department should provide foster parents with special service fees to cover the expense of an additional phone line for home monitoring of wards on probation.

The Department agrees with the need to provide foster parents with the financial assistance to obtain the necessary tools to do home monitoring of wards on probation. A comprehensive process will be developed to provide for exceptions to payment for foster parents in these situations. The process will be finalized by April 1, 2004.

DEATH AND SERIOUS INJURY INVESTIGATION 7

ALLEGATION

A 19 year-old Department ward was beaten and shot in the stomach by a group of people who accused him of sexually molesting two young girls.

INVESTIGATION

The ward, who had been involved with the Department since he was two years-old and had developmental disabilities, had lived in a private agency's residential facility for over six years before entering an independent living program operated by the same agency after he turned 18. The ward's caseworker encouraged him to enroll in school or secure employment but did not assume an active role to ensure the ward engaged in either endeavor. After less than one month in the apartment, the ward was evicted for disruptive behavior and allowing unauthorized guests to have access to the building. Following his eviction, the ward moved into the home of his oldest sister. The ward's caseworker visited the home and determined it to be a safe and appropriate residence. The caseworker and his supervisors agreed to allow the ward to remain in his oldest sister's home in a temporary approved placement.

A short time later, the caseworker learned the ward was actually residing in the home of his middle sister, also a Department ward, who was participating in a separate independent living program. The caseworker did not contact the private agency worker assigned to the girl's case to address the likelihood he was living in the home. The middle sister had two children and provided in-home daycare for four additional children, her boyfriend's nieces and nephews. An OIG review of police records found that officers responded to 11 emergency calls to the girl's home during the seven months she lived there regarding domestic disturbances, assault, property damage and medical emergency.

Three weeks after the ward's caseworker learned he was living in his sister's home, the ward was confronted at the residence by a man and woman who accused him of sexually molesting two young girls, ages eight and nine, that his sister had been caring for. The pair began striking the ward but left after he threatened to call the police. However, the couple later returned with a large group of men who began beating the ward. During the assault, one member of the group drew a gun and shot the ward in the stomach. The ward was taken to the hospital but refused to press charges. An investigation was opened into the allegations of sexual abuse.

The child protection investigator assigned to the case initially made a finding of sexual penetration by an unknown perpetrator. The ward was arrested on charges of child molestation and is currently awaiting trial. The OIG provided technical assistance which permitted the child protection investigator to develop additional evidence. The report was subsequently indicated against the ward.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Wards in Independent Living programs should be required to sign consents allowing caseworkers to contact their college or employment counselors. This requirement should be a part of the ward's subsidy agreement.

The Department's Division of Education and Transition Services will develop an agreement with wards who are in independent living programs that they must meet their obligation to stay in school and/or have employment in order to continue to receive their ILO payment. This agreement will be implemented by March 1, 2004.

2. The two private agencies should implement an effective monitoring and hands-on mentoring/coaching system to ensure youths' success in school and employment.

The Inspector General shared this report with both private agencies. The Inspector General met with the first agency's management staff and a member of the Board of Directors to discuss the report. The agency assigns an Independent Living Specialist to work very closely with each youth to address school and employment issues. As to the second private agency, the meeting was held in abeyance until the completion of another investigation involving the same agency.

2. The two private agencies' programs should develop a subsidy contract that clearly spells out expectations for receiving subsidies including incentives for achievements and disincentives for non-compliance. Youth should be fully apprised that agencies may obtain a history of police calls to their apartment to help determine their own and the community's safety.

The first private agency has a level program and incentive plan for its participants. The agency will continue to inform program participants of the program's ability to obtain criminal activity information and police contacts.

4. Child protection administrators and supervisors should a) immediately refresh child protection investigators on the existing policy on administrative subpoena power; and b) monitor compliance to ensure that child protection investigators obtain necessary medical and police documents for a thorough investigation.

The Department agrees. A policy transmittal will be issued to all child protection staff in order to remind staff of their ability to use administrative subpoenas during the course of child protection investigations by March 1, 2004.

5. The middle sister's caseworker and her supervisor should facilitate a family conference for the middle sister and her boyfriend to assist them in developing a plan to provide for their children.

A family conference was convened to develop a care plan for the children.

DEATH AND SERIOUS INJURY INVESTIGATION 8

ALLEGATION

A 17 year-old female Department ward allegedly murdered a 20 year-old female Department ward who resided in the same private agency-operated independent living complex. The murder occurred less than 12 hours after the 17 year-old was released from jail for a knife attack against a 21 year-old male former Department ward.

INVESTIGATION

The 17 year-old girl had spent her entire life as a Department ward. Following her birth, the girl's mother, who had a history of schizophrenia and psychiatric hospitalizations, became belligerent towards hospital staff and began threatening nurses with bodily harm. The mother was transported to a mental health center and the girl was taken into protective custody. The girl lived with a foster mother for five years, however when the foster mother died the girl was allowed to remain with the foster mother's daughter in an unlicensed placement. After the home was deemed unsuitable the girl was placed with her maternal great aunt who already cared for the girl's two younger siblings.

Three years later the maternal great aunt requested that the girl, then age eight, be removed from her home for repeated behavioral problems. The girl was removed from the home into what became a series of placements. During her time as a ward, the girl was placed in seven different foster homes and five separate residential institutions. In addition, she was hospitalized on 12 occasions for psychiatric care. The girl was determined to have low cognitive functioning and weak reasoning skills as well as an explosive temper that frequently manifested itself in verbal or physical outbursts towards whomever she identified as a source of conflict. Evaluators identified several psychiatric diagnoses. Numerous child welfare professionals involved with the girl recorded a pattern of remorseless violence towards peers, teachers and staff at various schools and residential facilities and an inability to either control or assume responsibility for her behavior or comprehend the ramifications of her actions.

After experiencing moderate levels of relative success at two residential facilities, the girl was transferred to a group home just prior to her 16th birthday. Following her acceptance to the group home, the girl's behavior deteriorated as she persistently directed aggressive behavior towards residents and staff. The girl and a group of fellow residents frequently left the facility campus without permission and openly engaged in substance abuse and sexual activity.

The girl's aggressive behavior lead to several inpatient psychiatric hospitalizations. The girl refused to comply with therapy or to take medication prescribed to her. Medical professionals were reluctant to prescribe medication because of the girl's frequent use of illicit drugs. The girl's ability to manipulate the group home's relatively permissive setting and the need to stabilize her environment before any substantive improvement in behavior could occur were also noted. Staff at the group home ultimately concluded the girl's participation in their program was ineffective and recommended the girl be placed in a more restrictive setting better suited to address her low functioning and extreme volatility. However, current in-state residential facilities were deemed insufficient to deal with the girl's needs. As staff and mental health professionals determined the girl's situation would only worsen if she remained at the group home, a Department administrator had the girl transferred to an independent living program operated by another private agency.

Despite the fact the girl had resided in institutional settings since she was 12 and demonstrated a need for increased limitations, she was entered into the independent living program at age 17 and provided with her own apartment and a small stipend. Throughout her involvement in the program the girl refused to comply with services and her caseworker and other involved workers noted her inability to provide for herself and disinterest in maintaining her home. Workers did note an improvement in the condition of the home after a 19 year-old woman who identified herself as the girl's cousin moved in. The "cousin" was actually a former

resident of the group home who had befriended the girl while they both resided there. Although the friend appeared to provide a stabilizing influence, her residency in the home violated the terms of the independent living program and the girl was instructed to end the arrangement.

In an interview with the OIG, the 19 year-old stated that after she moved out, she and the girl got into an argument in the apartment regarding the girl's expressed plan to sell crack cocaine. The friend left the apartment and went down the hall to another residence occupied by a 20 year-old female ward, a mutual friend. The girl then went to the apartment and began beating the 19 year-old, prompting the 20 year-old to call police. The girl was arrested for Domestic Battery and was held over for trial. The girl remained in jail for one month, three weeks of which she spent in solitary confinement for kicking another inmate in the face.

On the day the case was stricken on leave because of the victim's repeated failure to appear, the girl went to the offices of the private agency that operated the independent living program. Upon her arrival she requested the keys to the 20 year-old ward's apartment, representing to staff it was her residence. A private agency staff member gave her the keys but, upon realizing the error, requested that she return them. The girl refused and left the office. Private agency staff contacted the girl's caseworker and the 20 year-old ward. The caseworker met with the ward and made an unsuccessful attempt to locate the girl. The girl met with a 21 year-old male former ward and violently attacked him, slashing him on the throat with a knife. The girl was arrested however she was only charged with a misdemeanor and released on her own recognizance. Police did not request the State's Attorney's felony review to determine if more serious charges were warranted. The following afternoon, private agency staff found the 20 year-old female ward dead on the floor of her apartment. The girl was arrested and charged with three counts of Murder and four counts of Home Invasion. A subsequent felony review of the attack on the male ward resulted in the filing of additional charges of one count of Attempted Murder and three counts of Aggravated Battery. The girl was initially determined to be mentally unfit to stand trial but, following a stay in a psychiatric hospital, has been ruled fit and is awaiting trial.

A review of statewide psychiatric data on hospitalizations of wards conducted by a prominent professor of psychiatry found that readmissions of wards with multiple hospitalizations could be traced to the inability of most residential and foster care settings to adequately control the behavior of the highest risk children. The professor's analysis found that of all wards admitted for psychiatric hospitalization in 2001, 13% (152 wards) were hospitalized three or more times within a year. The professor determined this population was most likely to benefit from intense case management and recommended that such services be provided to wards who are hospitalized twice in one year or three times during a two-year period.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should identify teenage wards that are high-risk for continuing violence and assess the population for size, placement, and case status. This group will likely include the wards identified by the professor of psychiatry as receiving multiple psychiatric hospitalizations in a single year and wards that are involved in both delinquency and adult courts.

The Deputy Director for the Division of Clinical Services and Professional Development will provide data to the Director on the number of wards who are hospitalized and have violent tendencies by March 1, 2004. Integrated Assessment will target this population.

2. The Department should implement a multi-systemic therapy (MST) approach and an intensive case management program for the 12-13% of hospitalized wards with multiple yearly psychiatric hospitalizations (around 150 cases) and wards who are involved in both delinquency and adult courts.

The Department is currently piloting an MST project with the Cook County Juvenile Court.

3. The Department should immediately cease placing youths under 18 years of age in unsupervised apartments. For wards 18 + years in the high-risk category (identified above), the Department should require progressive step-down placements prior to independent living. The Department should not place high-risk youth in an ILO placement unless they have demonstrated progress in a transitional (supervised) living arrangement. This would exclude placing a ward from a psychiatric hospitalization directly into an unsupervised living arrangement.

The Department is currently in the process of changing policies as they relate to the 5,200 youths over 18 years of age the Department has a relationship with by June 1, 2004. This recommendation will be part of those changes.

4. The Department should develop a placement model similar to halfway houses for high-risk wards (17 years and older) who have been released from the Juvenile Division of the Department of Corrections or are violating probation orders. The ward should be held strictly accountable for school, work, curfew, etc. The Department should consult with programs such as Safer Foundation or Isaac Ray regarding the development of secure halfway houses.

The Department is currently in the process of changing policies as they relate to the 5,200 youths over 18 years of age the Department has a relationship with by June 1, 2004. This recommendation will be part of those changes.

5. The Department has been remiss in its fiduciary duty by not establishing secure facilities for youth whose behavior poses an established pattern of foreseeable serious risk of bodily harm to self or others (as specified in DCFS Rule 411).

The Department's management team coordinator is leading an interagency committee on secure facilities.

6. The Guardian's Office has to proactively meet its responsibility, "to assure a permanent, secure and nurturing living arrangement for each child the Department serves." The Guardian's office should assemble a panel to examine the present population of high-risk wards, recommend placement / treatment options, make recommendations about how to sustain an on-going effort to review high-risk cases and examine which may need court review for compliance with mental health services. The panel should include: the guardian, psychologists, psychiatrists, a pharmacologist, adolescent health experts, ethicists and selected independent examiners (per Rule 411). The panel should designate a smaller group available to the Guardian for on-going consultation in these extreme cases.

The Deputy Director for the Division of Clinical Services and Professional Development will work with the management team coordinator and the mental health interagency group on this issue.

7. The Department should fund an evening intervention center for the local communities, similar to the current models utilized by the Juvenile Court in Chicago. Assignment to the evening intervention center would be incorporated as part of a court order for supervision or probation and involving separate facilities for youth ages 13-16 years old and young adults 17-18 years old. The program should implement anger replacement therapy [ART combines anger control training (emotional), psychological skill stream training and moral reasoning]. The evening intervention center should have the capacity to supervise court ordered community service and time spent in the center should be scaled to a youth's progress at the evening intervention center, community, and school. The residential facilities should arrange for transportation of their clients. Following the balanced and restorative justice model, adult mediators can be used for conflict resolution between the delinquent wards and

their victims.

The Department is not rejecting this recommendation, however this issue will be addressed again in June, 2004 when new contracts have been implemented. It will be considered a potential issue for fiscal year 2005.

8. The private agencies that operate the group home and the independent living program, respectively, should immediately develop and implement violence prevention / intervention programs for state wards in their custodial care. See the OIG's Report to the Governor on Violence.

The Department agrees. The Director will send a letter to the agencies instructing them of the need to develop violence prevention and intervention programs.

9. The contractor did not use a community psychiatry/psychology approach when working with the girl. Since the consulting psychologist's work on this case was representative the contractor's services, then the Department should examine if the multi-systemic therapy model for weekly program consultation would be more effective. The contractor should examine whether they should consult with neurological specialists on Department cases.

The Department agrees to review the services provided by the contractor and, as appropriate, adjust their contract to provide clear contractual responsibilities for the issues identified.

(The contractor objected to the findings of this report and stated that their role under the contract was strictly consultative and they should not be held responsible for case management decisions. The contractor is part of the same entity as a neurological specialist, "meaning by definition that 'consultation' with [the neurological specialist] occurs in every case.")

10. A redacted version of this report should be shared with the Boards of Directors of the private agency that operates the group home and the private agency that operates the independent living program. The Inspector General will meet with the Boards to discuss the findings and recommendations.

The Department agrees. The OIG shared the report with both agencies and met independently with their respective management staffs and members of their Boards of Directors to discuss the report.

11. If the Department continues to contract with the contractor, the contractor's time frame for involvement should be restricted to 90 days and specific deliverables identified. At a minimum, a contractor's aftercare program should include:

a) A program plan within 30 days that includes a client psychiatric appointment with transfer of all mental health records and a treatment meeting between the outgoing and incoming psychiatrists,
b) Consultation on strategies to implement contractor discharge recommendations, and
c) A complete handoff to the new mental health team within 90 days.

The contractor's discharge planning should include:
a) Department clinical staff at the discharge staffing,
b) Department educational coordinators from the region of the child's placement at the discharge staffing, and
c) For a seamless educational transition, any child who has special education entitlements should be re-integrated into special education services by involving the school in the discharge planning.

Within 90 days, the contractor should produce a report for the agency and the Department evaluating the implementation of the contractor's recommendations.

The Department agrees to review the services provided by the contractor and, as appropriate, adjust their contract to provide clear contractual responsibilities for the issues identified.

DEATH AND SERIOUS INJURY INVESTIGATION 9

ALLEGATION A mother and her boyfriend were the subjects of multiple allegations of abuse, including an indicated report for risk of harm, against her seven year-old son while the family had an open case with Intact Family Services (IFS).

INVESTIGATION The family first became involved with the Department six years earlier when the maternal grandmother called the hotline to report the mother had left her then two year-old son locked in a bedroom alone while she went out with friends. The report was indicated for inadequate supervision and referred for intact services. The mother completed parenting classes and the case was closed, however it was reopened three years later after hospital staff attending to the mother during a medical procedure observed the boy had numerous loop and whip marks on his body, including his head and face. Following a child protection investigation which resulted in an indicated finding against the mother for cuts, welts and bruises, an intact worker was assigned to provide support and services.

As part of the IFS program, the mother and her son began participating in therapy. A short time after the sessions commenced, the boy told the therapist that his mother's boyfriend sometimes hit him and later reported an injury he attributed to one such incident. The therapist related her concerns for the boy's safety to the intact worker's supervisor but recorded in her case notes that the supervisor stated there was no evidence the boyfriend ever harmed the boy. The therapist then contacted the hotline which accepted the report as information only and forwarded it to the intact worker.

Two months later, the intact worker made an unannounced visit to the home and observed what she determined to be fresh bruises on the boy's face and a bloody scratch on his head. The worker called the hotline and a child protection investigator was assigned to the case and instructed to ensure the boy received medical attention. The mother told the investigator she had "popped" her son but denied whipping him, explaining that she was interrupted by the intact worker's arrival at the home. The mother told the investigator that she and her son were making progress in therapy and expressed her belief the intact worker was attempting to have her son removed from her custody. The investigator determined that the boy did not require medical attention and completed a Child Endangerment Risk Assessment Protocol (CERAP) which concluded the child was at no risk. A follow-up investigator spoke with the intact worker's supervisor who told her he met with the family four days after the report was made and observed no signs of injury to the boy. In addition, the supervisor stated the intact worker had "exaggerated the situation" and that he had transferred the family's case to another worker, at the mother's request. The investigator did not speak with the therapist who worked with the mother and her son. In an interview with the OIG, the follow-up worker stated that the supervisor's statements led her to question the intact worker's credibility and played a significant role in her decision to unfound the report.

Soon after the second intact worker assumed responsibility for the case, the mother was scheduled to undergo knee surgery that would inhibit her ability to transport herself and her son to therapy sessions. Although the therapist and psychologist working with the family requested Department transportation assistance, the intact worker and the supervisor stated such efforts were not their responsibility. The mother and her son did not return to therapy.

Two months later, the intact worker accompanied members of the Parenting Assessment Team (PAT) on a visit to the home. During the visit, the boy began misbehaving and at one point held his mother's purse out the window. As she was leaving, the intact worker cautioned the mother not to use corporal punishment in response to the behavior. Three days later, PAT staff saw the boy and observed fresh scratches and marks on his head and neck. The boy was taken for medical treatment and the intact worker was notified. The child protection investigator assigned to the case spoke with the treating physician who stated both the mother and

child had acknowledged the mother accidentally scratched him during an attempt at discipline. The doctor expressed her concerns regarding the mother's ability to control her impulses when dealing with her son. The investigator then interviewed the mother and son who confirmed the doctor's report. The mother stated that although she had hit her son in the past and was trying to stop resorting to such behavior, she frequently became impatient with him. The mother also informed the investigator she had stopped giving her son the Ritalin he had been prescribed to control his diagnosed Attention Deficit Hyperactivity Disorder (ADHD). The investigator spoke with the IFS worker who stated she did not believe the boy was at risk and that the mother would not intentionally hit her son. Although the mother later admitted to the intact worker she had struck her son during the incident, the worker did not relay this information to the investigator. The investigator subsequently indicated the report for risk of harm but unfounded the report for cuts, welts and bruises.

The day before the parenting assessment was completed, the intact worker asked a Department clinical coordinator to conduct an assessment. The clinical coordinator, who was aware of the pending PAT report, completed a one-page report based on the intact worker's description of the family without meeting with the family or reading the case record. The following day, the intact worker received the conclusions of the PAT. The PAT assessment was a comprehensive document completed after several observations of the family and a review of case records. The PAT recommended the boy be removed from the home and that the mother receive individual therapy to improve her individual functioning and address her anger management problems. If the boy was to remain in the home, the PAT concluded that services should focus on in-home intervention and monitoring to offset the high level of risk. The clinical coordinator did not participate in the meeting and instead sat with the boy in his room. An OIG review of the clinical coordinator's case notes found that during that time, the boy asked her if she was going to ask him about what was going on in the home. In an interview with the OIG, the clinical coordinator stated she did not want the boy to be "bombarded with questions" and did not pursue his attempt to share information. After PAT staff left the home, the clinical coordinator assured the mother her son would not be removed from her care.

Although the PAT assessment was comprehensive and included interviews, documentation and observation from numerous involved professionals, the intact worker wrote a service plan in which she disregarded their recommendations. The intact worker presented her plan to her new supervisor, who had taken over the intact team, and it was approved for implementation. In an interview with the OIG, the second intact supervisor stated he had never heard of the PAT until he received their report and that he did not notice the service plan failed to incorporate the PAT recommendations. The second intact supervisor acknowledged he did not read the report and stated he was overburdened and looking forward to an early retirement.

Five months later, the intact worker recommended that the family case be closed. The worker based her decision on the mother's involvement in an employment assistance program, her commitment to administering her son's medicine, the boy's participation in therapy and the resolution of risk factors in the home. The second intact supervisor approved the decision and the family case was closed. The intact worker did not verify the information used to support her conclusions but relied on the mother's reports and her own assumptions. The OIG found that the mother failed a drug test required to participate in the employment program and quit rather than engage in substance abuse counseling. The second intact supervisor never read the full case record but accepted the worker's representation and acquiesced to her decision to close the case.

Three months after the case was closed, hospital staff called the hotline to report that the boy had jumped out of a first floor window to avoid being whipped by his mother and the boy reported that she had previously bitten him. The report was indicated for risk of harm and medical neglect and an intact case was opened for the third time. The child protection investigator did not conduct a LEADS check of the mother's boyfriend who continued to spend a significant amount of time in the home. The results of a LEADS check of the boyfriend conducted by OIG investigators were forwarded to intact staff. In response to pressure to

temporarily remove the boy from the home, the intact worker contacted the hotline and reported medical neglect based on the mother's failure to administer the boy's prescribed Ritalin. The boy was taken into protective custody, however the State's Attorney's Office decided against screening the case into court and the boy was returned to his mother. The case remains open for intact services.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should amend section 6.5a of the LEADS protocol to eliminate allegation #11's restrictions to age and disability.

The Department agrees to amend the LEADS protocol.

2. Portions of this report that pertain to child protection investigations should be used as a training tool for child protection investigation staff in addressing risk as well as the importance of obtaining collateral information.
The Department agrees and this report will be used in training for child protection staff.

3. Intact Family Services staff must be retrained in the paramour policy and LEADS. The training should emphasize the importance of conducting criminal background checks and assessing arrest information whenever there is a risk of violence in the home should be emphasized.

The Department agrees. The training will be held.

4. Intact Family Services should closely monitor this case to ensure the mother's continued involvement in services, including the Parenting Assessment Team's recommendations, to assess on-going risk, and provide support. Intact Family Services staff must ensure the boy receives a case study and that all recommendations from his individualized educational plan are followed; the mother's boyfriend's continued presence and unsupervised visits to the home should be recognized as a safety risk to the boy. A safety plan should be put in place excluding him from the home; if Intact Family Services has any suspicion that corporal punishment is continuing to be used, the case should be immediately screened into court for risk of harm and an order of protection requested.

The Department agrees. The OIG has been working with the Department in implementing this recommendation.

5. The OIG will flag the second intact worker's name on the child welfare licensure listing, so if she reapplies for child welfare employment, OIG staff will be notified, and she can be counseled regarding her handling of this case.

The Department agrees.

6. The Department should pursue disciplinary action against the first intact supervisor for failure to document significant incidents, including a meeting with the family after the worker called the hotline, for no evidence that he weighed the credibility of the worker or the client prior to reassigning the case, and for failure to appropriately respond when a mandated reporter, in this case hospital staff, made a report of possible abuse to the boy.

The first intact supervisor was given a verbal reprimand.

7. The Department should pursue disciplinary action against the second intact supervisor for: failing to ensure that identified services for the family were provided prior to closing the case, neglecting to read the record, and neglecting to ensure the worker addressed the risk issues or followed the recommendations in the Parenting Assessment Team report.

The second intact supervisor was given a one-day paper suspension.

8. A redacted copy of this report should be used in LEADS and CERAP trainings.

The Department agrees. The report will be used in training.

9. The Department should pursue disciplinary action against the clinical coordinator for disregarding the findings and recommendations of the Parenting Assessment Team and for conducting a substandard risk assessment.

The clinical coordinator was given a written reprimand.

10. The actions of the Department's clinical division are part of a pattern identified by OIG staff (OIG Reports #021406, June 26, 2002; #021484, June 17, 2000; #010930, June 27, 2002; and, #011047, December 10, 2001) of clinical decision-making without a record review, necessary professional consultation, accountability for deviation from clinical practice, evidence-based standards, and elimination of operating biases. The OIG is therefore recommending that future clinical input be suspended until a system is put in place that ensures clinical decision-making that complies with sound clinical practice standards.

The Department disagrees with this recommendation.

DEATH AND SERIOUS INJURY INVESTIGATION 10

ALLEGATION

A six year-old boy died after being beaten by his stepmother. Four months prior to his death, the boy had been removed from a private agency's residential facility and placed with his father and stepmother, who lived in another state.

INVESTIGATION

The boy initially became involved with the Department when he was two years old after he was brought to a hospital emergency room for treatment of various injuries including a human bite mark, a healing cigarette burn and bruises to his arm and forehead. The boy's father, who brought him to the hospital, reported that he and his wife had discovered the injuries after picking him up from the home of the boy's biological mother for a weekend visit. A police officer at the hospital contacted the hotline and a child protection investigation was initiated. The child protection investigator interviewed the father and stepmother who stated that the boy resided with his mother but stayed with them once a month for periods of two days to one week. Five days had elapsed between the time the boy was picked up from his mother's home and when he was brought to the hospital. The father told the investigator the delay was because of his desire to speak with the mother first regarding the injuries. The investigator ultimately indicated the report against the mother and father for human bites, burns and cuts, welts and bruises but was unable to determine which parent had caused the injuries. The Department was granted custody and the boy was placed with his maternal aunt and uncle following his discharge from the hospital. The case was assigned to a private agency to provide services.

The father, mother and stepmother participated in services independently, however over time, the mother's involvement dwindled to a halt. In an interview with the OIG, the boy's first caseworker stated that, subsequent to the child protection investigation, the private agency caseworker and her supervisor became concerned about the stepmother's fitness to care for the boy. Following the completion of the investigation, private agency staff learned that during the five days between when the boy was picked up from his mother's home and when he was taken to the hospital, he had primarily been in the stepmother's care because the father was away with friends. The caseworker also related to OIG investigators an incident that occurred at the private agency's office. The caseworker stated that while the family was at the agency, the stepmother took the boy to use the bathroom. When they returned, staff observed marks on the boy's face that resembled the bathroom floor tiles. Both the stepmother and the boy told staff he had fallen in the bathroom and hit his head. The boy's foster parent took him to a doctor later that day. The doctor concluded the marks could not have been the result of a fall. Although the caseworker completed an unusual incident report (UIR), no hotline call was made. The caseworker told the OIG she did inform the presiding judge of the incident during a progress hearing and the judge assured her the boy would not be returned to the custody of either parent until the perpetrator of the original abuse was identified. The family's case was later transferred to another private agency and a new judge was assigned.

The boy, who was almost five years-old, functioned at an eighteen month-old level. The boy was placed in a residential facility. The boy demonstrated mild oppositional and defiant behaviors, became physically aggressive and defensive when challenged, was hyperactive and displayed "grossly impaired" speech. After living in the facility for one month, staff recorded the boy's behavior and speech had improved significantly, though further services were obviously required. One month later, the father contacted the agency and informed staff he and the stepmother, who had moved to another state, wanted the boy to come live with them. The father and stepmother, who had two children of their own, then ages two and three, began attending individual and family counseling through a private agency in their new home state.

The private agency initiated a request for an out-of-state home study through the Interstate Compact Office. The initial home study recommended not placing the boy with his father and stepmother because of the unresolved issues surrounding the prior abuse and a less than favorable assessment of the stepmother's

parenting abilities. A second home assessment, however, ignored the unresolved abuse and recommended placement with the father and stepmother. Based on the second home study, the new judge ordered immediate placement with the father and stepmother. The Interstate Compact Office failed to ensure that services were in place at the new home until six weeks after the child was moved. The Office also failed to ensure that the services provided by the receiving state were commensurate with services required in Illinois when a child is returned home after being abused or neglected. Illinois requires a worker to conduct an in-person visit with a child within 24 to 48 hours of being returned home. In addition, workers must conduct weekly monitoring visits for the first month and monthly visits until the case is closed. The Interstate Compact required visits only every three months.

One month after the boy was placed in the home the family's therapist contacted the Illinois caseworker and informed her the boy had been moved to another school because of persistent physically aggressive behavior. In addition, the stepmother had reported finding the boy and his three year-old step-sister unclothed together in bed. Two months later, the Illinois caseworker received a call from the stepmother who stated she felt overwhelmed by the boy's behavior in the home and questioned whether she and the father could continue to care for him despite the services they were receiving. The following week the mother called again to say she felt better and had only needed to "vent" her feelings. One month later the boy was taken by the father and stepmother to a hospital emergency room and received six metal staples to close a head laceration. The father and stepmother told attending physicians the boy had fallen down the stairs while in the stepmother's care. Although the family's therapist saw the boy later that day after he was released from the hospital, neither the therapist nor hospital staff contacted child welfare professionals in either state to notify them of the serious injury to the boy.

Five days after the head laceration, the father and stepmother brought the boy back to the emergency room with numerous bruises and wounds consistent with physical trauma. The boy died from his injuries two days later. The stepmother confessed to police she had repeatedly kicked and punched the boy. She stated his behavioral problems had caused her a great deal of stress and she had become frustrated by his ability to withstand physical pain without complaint.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Interstate Compact procedures should be amended to ensure that workers request specific services to fulfill the requirement in Rule 328 that services must comport with existing Department Rules. The Office should develop a form to prompt referring workers and supervisors to identify and request services that would be required if the family were living in Illinois.

The Department will work in conjunction with the OIG to strengthen Department policies and procedures related to the Interstate Compact.

2. Procedures for Rule 328, Interstate Compact, should be amended to provide timelines for submission of the Interstate Compact Form 100B that is used to initiate out-of-state service provisions. The procedures must require that the case manager transmit the form to the Interstate Compact Office within 48 hours of a court-ordered placement. The Interstate Compact Office must transmit the form to the receiving state within 5 days of submission.

The Department will work in conjunction with the OIG to strengthen Department policies and procedures related to the Interstate Compact.

3. The Interstate Compact Office must proactively communicate with the receiving state to ensure that services begin from the first day of placement.

The Department will work in conjunction with the OIG to strengthen Department policies and procedures related to the Interstate Compact.

4. Case managers and supervisors must be trained and procedures must reflect that when an out-of-state placement is being considered, paperwork must be prepared in advance and the Interstate Compact Office notified in advance of the court date.

Once procedures have been changed, training for staff will follow.

5. If the court has ordered out-of-state placement and it is impossible to ensure services from the date of placement, the court must be immediately notified of that fact.

All Office of Legal Services attorneys were notified on September 8, 2003 of their responsibility in cases that have interstate involvement.

6. This report should be shared with the private agency and the receiving state's Department of Human Services.

The Department agrees. The OIG shared the report.

DEATH AND SERIOUS INJURY INVESTIGATION 11

ALLEGATION

A 16 year-old developmentally delayed boy living in a residential placement facility drowned in a swimming pool during a group outing to a private residence.

INVESTIGATION

A facility employee, who served as director of recreation, took the boy and five other youths, all between the ages of 12 and 18, on a trip to a resort complex where he held an interest in an apartment as part of a time-share arrangement. At the time of the incident, three of the boys were in the swimming pool while the employee and the other boys sat nearby. The 16 year-old and another boy went into the deep end, later measured by local police as 12 feet deep, in order to retrieve a pool toy. The two boys dove down to retrieve the toy, however the second boy re-emerged and called for help, stating the 16 year-old was having difficulty. The employee responded that the 16 year-old knew how to swim and would be fine. When the second boy insisted the 16 year-old needed assistance, the employee asked another youth, who was not in the pool, to dive in and bring the 16 year-old to the surface. The third boy and a bystander pulled the 16 year-old out of the pool. The bystander and another individual at the pool administered Cardio Pulmonary Resuscitation (CPR) until paramedics arrived. Attempts to revive the boy were unsuccessful and he was pronounced dead at the hospital.

On the day of the incident, the State Central Register (SCR) was contacted and informed of the death of a ward. The reporter stated four of the children who had gone on the trip were refusing to return to the residential facility and requested that an on-call child protection worker travel to the complex. The on-call worker went to the complex and conducted interviews with the other children. The issue of the boys returning to the facility was resolved and the on-call worker contacted the hotline. The hotline designated the information as an Unusual Incident Report (UIR) rather than a report for investigation based in part on the on-call worker's erroneous account that a lifeguard had been on duty at the time of the drowning.

The OIG obtained the findings of the police investigation into the drowning which contradicted the report that a lifeguard had been on duty. Local police had learned the pool did not have a lifeguard on duty and that signs to that effect were posted around the pool. In addition, police learned the employee did not know how to swim. Based on this additional information, the OIG requested a child protection investigation into the boy's death as well as a licensing investigation of the residential facility regarding procedures for group outings involving wards. The Department's division of child protection and division of licensing initiated separate investigations based on the OIG requests.

The child protection investigator assigned to the case determined the employee should be indicated for death by neglect for the drowning of the 16 year-old and risk of physical injury to the boy that was swimming with him as well as the boy who was asked to pull the 16 year-old out of the water. The investigator based her decision on the fact that the employee, who had previously taken facility residents on similar outings to the same pool, had allowed children to swim under his supervision while being aware that there was no lifeguard on duty and that he himself could not swim. The investigator concluded the employee placed the 16 year-old and the second boy in danger by allowing them to swim in the deep end, then exacerbated the situation by instructing the third boy to jump into the water to save the drowning boy. The investigator also found that the 16 year-old's caseworker had not given permission for him to participate in the outing and that although the employee had informed the residential facility he was able to swim and knowledgeable of CPR techniques, the facility never verified the information. The indicated findings against the employee were approved and his employment was subsequently terminated by the residential facility.

The licensing division investigation found a number of violations committed by the residential facility including failure to formulate a written policy regarding recreation activities and schedules, failure to evaluate

the appropriateness of a recreational facility, and the employee's failure to adequately assess the 16 year-old's ability to participate in a recreational activity. The residential facility was informed of the violations and is currently constructing a corrective action plan.

** The OIG did not conduct the formal investigation into this incident due to a potential conflict of interest within the office. The OIG relied upon investigations conducted by local police, the division of child protection and the division of licensing to produce this report.*

CHILD DEATHS

The OIG receives notification from the Illinois State Central Register (SCR) of child deaths, reported to SCR, 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.[1]

The notification of a child death generates a preliminary investigation in which the death report is reviewed and computer databases are searched. If available, a chronology of the child's life is reviewed. When further investigation is warranted, records are impounded, subpoenaed, or requested, and a review is completed. When necessary, a full investigation, including interviews, is conducted. Reports are issued to the Director. In Fiscal Year 2003, the OIG received notification from SCR of 122 child deaths meeting the criteria for review.[2] In 21 cases preliminary investigations were conducted. In 78 cases records were reviewed. In 13 cases reports were sent to the Director, including 9 cases that were included in larger cluster reports. One full investigation was completed with no report sent to the director. Nine full investigations are still pending. Summaries of death investigations that resulted in major recommendations are included in the Investigations section of the annual report.

In FY 03 the OIG completed a cluster report addressing the topic of infant sleep safety after a pattern of infant deaths related to sleep was noted. The American Academy of Pediatrics has issued guidelines for infant sleep safety. Infants who are substance exposed, a large portion of the population served by the Department, are especially vulnerable to SIDS. The OIG looked at seventeen cases in which children under the age of one year, meeting the criteria for OIG review, died in their sleep or after being put to bed. Nine of these children died in FY 02. Eight of the children died in FY 03. The risk of death from Sudden Infant Death Syndrome (SIDS), asphyxia by overlay, positional asphyxia (trapping between two surfaces), and suffocation due to soft materials in bed may be reduced through educating and encouraging families to utilize safe sleep strategies. This report, Child Death Investigations Involving Infant Sleep Safety, can be found in Appendix B.

Following is a statistical summary of the 122 child deaths received by the OIG in FY 03 as well as summaries of the individual cases.

Homicide

There were a total of 25 deaths classified homicide in manner.

* 8 minors died from gunshot wounds
* 6 children died from inflicted head trauma
* 3 children died from inflicted abdominal trauma
* 2 children died from suffocation

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[1] The limitations of this information should be noted. The State Central Register relies on coroners, hospitals, and law enforcement throughout the state to report child deaths to the hotline, even when the deaths are not suspicious for abuse or neglect. Currently, there is no statewide policy for the reporting of child deaths to SCR. Therefore, true statistical analysis of child deaths in Illinois cannot be performed because the total number of Illinois children dying each year is unknown. The Cook County Medical Examiner's policy is to report to SCR the deaths of all children autopsied at the medical examiner's office. The Child Death Review Teams throughout the State are requesting that coroners in Illinois report all child deaths to SCR. They have also requested that SCR receive child death certificates from individual county registrars.

[2] The OIG received 97 cases for review in FY 02.

* 2 children died from multiple inflicted injuries
* 1 minor died from a stab wound
* 1 child died from drowning
* 1 child died from sepsis because she was so battered
* 1 child died from malnutrition

Perpetrators[3]
* 4 boyfriends
* 4 babysitters
* 4 mothers
* 3 fathers
* 2 stepfathers
* 1 cousin
* 1 grandmother
* 8 non-caretakers

Male/Female Breakdown of Perpetrators
*18 Males
* 10 Females
* 1 unknown perpetrator

Number of Perpetrators Charged
* 23 perpetrators have been criminally charged in 19 child deaths
  * 17 are awaiting trial
  * 6 have been convicted
* There have been no charges in 6 cases

County
* 1 death in Champaign County
  (case management Edgar County)
* 16 deaths in Cook County
  (1 case management in DuPage County)
* 1 death in Macon County
* 1 death in St. Clair County
*2 deaths in Winnebago County
* 1 death in Hennepin County, Minnesota
  (case management Cook County)
* 1 death in Milwaukee County, Wisconsin
  (case management Cook County)
* 1 death in St. Louis County, Missouri
  (case management St. Clair County)
* 1 death in Weber County, Utah
  (previous investigation in Madison County)

Ages of Children
* 2 children under 6 months
* 3 children ages 6 to 11 months
* 5 children ages 12-24 months
* 3 children age 3 years
* 1 child age 4 years
* 1 child age 5 years
* 1 child age 6 years
* 1 child age 9 years
* 1 child age 13 year
* 2 children age 15 years
* 2 children age 16 years
* 1 child age 17 years
* 3 wards age 18 years or older

Ages of Perpetrators[4]
* Male perpetrators were from 18 to 36 years
* Female perpetrators were from 18 to 46 years

Substance Exposure at Birth
None of the children killed were reported to DCFS for substance exposure at birth

[3] A perpetrator is one who was indicated by DCFS, charged criminally, or both indicated and charged.
[4] There is one perpetrator of unknown age.

Suicide

There was one death classified as suicide. A fifteen-year-old hanged himself at his foster home. The death was in Tazewell County.

Through the process of conducting investigations, the OIG has encountered an alarming number of cases in which death and serious injury could have been prevented had professionals involved with cases involving homicide and suicide acted more knowledgably about risk factors for violence and strategies to prevent it. In the OIG's Special Report to the Governor on Violence Prevention, we summarize some of what we have learned from these investigations and offer recommendations to ensure that good practice procedures for preventing violence are established. (Please see Appendix A.)

Undetermined

A death is classified as undetermined in manner when there is insufficient information to classify the death as homicide, 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 three possible manners of death. In nearly all cases involving infants and children the decision rests between homicide and one of the other two possible manners: accident and natural. Thus, there is a certain degree of suspicion attached to undetermined causes and manners.

There were a total of 8 deaths classified undetermined in manner.

* 5 children also had an undetermined cause of death
* 2 children died of drowning (1 in a pool, 1 in a bathtub)
* 1 child died from bronchopneumonia due to drowning (in a bucket of water)

Ages of the Children
* 2 children were 3 months and under
* 4 children were 4 to 12 months
* 2 children were 13-24 months

Substance Exposure at Birth
* 2 children were born substance exposed

County
* 8 deaths occurred in Cook County

Accident

There were a total of 23 deaths classified accident in manner.

* 14 children died from asphyxia/sleep related deaths
    - 8 children died from Asphyxia due to overlay
    - 4 children died from positional asphyxia (trapping between two surfaces)
    - 2 children died from suffocation/asphyxia from soft material in bed with them
* 6 Children died from fire related deaths
    - 4 children died from carbon monoxide intoxication
    - 1 child died from thermal injuries
    - 1 child died from smoke inhalation
* 5 children died from drowning
    - 1 drowned in a sump pump

- 2 children drowned in a bathtub
- 2 children drowned in a pool

* 3 children died in motor vehicle-related accidents
  - 1 child was hit by a train
  - 1 child was hit by a car
  - 1 child was riding his bike and was hit by a truck
* 1 child died from hanging with a blind cord
* 1 child died from strangulation with mattress trimming
* 1 child died from an undetermined cause (probable suffocation)

Ages of Children
* 11 children were 0 to 3 months
* 7 children were 4 to 12 months
* 2 children were 13 to 23 months
* 3 children were 2 years
* 1 child was 3 years
* 2 children were 4 years
* 2 children were 7 years
* 2 children were 10 years
* 1 child was 12 years

County
* 18 deaths occurred in Cook County
* 1 death occurred in Jackson County
* 1 death occurred in Knox County
* 1 death occurred in Lake County
* 1 death occurred in Madison County
* 1 death occurred in Morgan County
* 1 death occurred in Peoria County
* 2 deaths occurred in Sangamon County
* 1 death occurred in St. Clair County
* 1 death occurred in Will County
* 2 deaths occurred in Winnebago County
* 1 death occurred in St. Louis County, Missouri (Case Management in St. Clair County)

Substance Exposure at Birth
* 1 child tested positive for drugs at birth

Natural

There were a total of 57 deaths classified natural in manner.

* 11 children died as a result of complications from premature births (7 of the mothers had histories of drug and/or alcohol abuse)
* 9 children died from cancer related complications
* 7 children died from progressive illnesses
* 7 children died from Sudden Infant Death Syndrome (SIDS)
* 6 children died from complications of multiple medical problems
* 6 children died from cardiac disease or complications from heart problems
* 5 children died from respiratory complications, asthma or pneumonia
* 2 children died from complications due to sepsis
* 1 child died from an undetermined cause following a prodrome of lethargy, emesis and shortness of breath
* 1 child died from Herpes Simplex and severe pulmonary consolidation
* 1 child died from complications of a viral syndrome
* 1 child died from dehydration due to gastroenteritis

Ages of Children

* 5 children died on the day they were born
* 21 children were 0 to 3 months
* 5 children were 4 to 6 months
* 7 children were 7 to 12 months
* 1 child was 13 to 23 months
* 1 child was 2 years
* 2 children were 3 years
* 3 children were 4 years
* 2 children were 5 years
* 1 child was 6 years
* 1 child was 10 years
* 1 child was 12 years
* 2 children were 15 years
* 2 children were 16 years
* 2 children were 17 years
* 1 child was 18 years

County

* 1 death occurred in Alexander County
* 37 deaths occurred in Cook County
* 1 death occurred in Fulton County
* 1 death occurred in Hamilton County
* 2 deaths occurred in Macon County
* 2 deaths occurred in Madison County
* 1 death occurred in McHenry County
* 2 deaths occurred in Sangamon County
* 1 death occurred in St. Clair County
* 2 deaths occurred in St. Louis, Missouri
* 1 death occurred in White County
* 1 death occurred in Will County
* 5 deaths occurred in Winnebago County
* 1 death occurred in Broward County, Florida (case management Will County)
* 2 deaths occurred in St. Louis, Missouri (case management in Clay and St. Clair counties)

Substance Exposure at Birth

* 16 children were born substance exposed
* 8 more mothers have histories of substance abuse

Deaths in Which the Manner of Death Was Ruled Homicide by the Medical Examiner or Coroner's Office

Case # 1 **DOB November 1983** **DOD June 2002**
Age at death: 18 years
Substance exposed: no
Cause of death: gunshot wound to chest
Perpetrator: cousin
County: Minneapolis, Minnesota (death)
Cook (case management)
Narrative: Eighteen-year-old ward was shot in the chest by his twenty-year-old cousin following an argument. The cousin surrendered to authorities and pleaded guilty to second degree murder. He was sentenced to twelve years. At the time of his death, the ward was on run and was believed to be living in Minnesota with his mother. Prior History: The ward entered foster care with two siblings in April 1995 after being neglected by his mother. The ward had a history of running from his placements. His final placement was with his maternal great-aunt. He ran from this placement in February 2002. The OIG conducted a preliminary review of this ward's death.

Case # 2 **DOB September 1992** **DOD July 2002**
Age at death: 9 years
Substance exposed: no, however, mother has a history of substance abuse
Cause of death: malnutrition
Perpetrator: mother
County: Cook
Narrative: Nine-year-old girl, who suffered from cerebral palsy, was found dead by a family friend who went to check on her. She had been dead for some time before being discovered. The child weighed only 38 pounds at death, the weight of an average four-year-old. Cerebral palsy was listed as a significant condition contributing to the child's death, but not resulting in the underlying malnutrition. The twenty-five-year-old mother was indicated for the child's death. No criminal charges were filed. Prior History: The mother gave birth to the child at age sixteen. The child suffered from hypoxic brain damage during birth. The resulting cerebral palsy left the baby non-verbal and non-ambulatory, with severe developmental delays. The family came to the attention of DCFS in May 1999 when the twenty-three-year-old mother was indicated for medical neglect after she did not comply with treatment needed for the child's seizures. An intact family case was opened until December 1999 to provide the mother with services for the child and her two-year old sibling. In April 2001, a second intact family case was opened after the mother gave birth to twins, one of whom tested positive for cocaine. A member of the mother's family moved in to assist her with the twins while the Department attempted to engage the mother in substance abuse treatment and homemaker services. In September 2001 the school contacted the hotline to report that the child had lost weight over a long weekend and had to be hospitalized for seizures. An investigation of neglect was unfounded. During the course of the intact family case, the mother did not participate in drug services, but did do random urine drops which were negative for drugs. The mother refused homemaker services and assistance to the family focused on locating adequate housing. The intact family case was closed in June 2002. The child had not attended school for the three months prior to her death. Following the child's death, her siblings were taken into custody. The oldest was placed with his father and the twins are in a foster home with a goal of return home. The OIG conducted a full investigation of this child's death. A report was sent to the director on September 15, 2003.

Case # 3 **DOB October 2000** **DOD July 2002**
Age at death: 1-1/2 years
Substance exposed: no
Cause of death: suffocation
Perpetrator: mother
County: Cook
Narrative: One-and-a-half-year-old child was suffocated after his twenty-one-year-old mother pushed a mattress and box spring on top of him. The mother told police she was stressed about moving out of her apartment, and she confessed to hitting the child and pushing the mattress and box spring on the child in anger. The mother was charged with first-degree murder and is currently awaiting trial. Her next court date is in January 2004. She has no other children. Prior History: The mother was a former ward who had a history of depression and suicidal ideation and suffered from sickle cell anemia and untreated thyroid disorder. She had aged out of the system twenty days before the child's death. Prior to her emancipation, she was in an independent living program, residing with her son. The OIG conducted a full investigation of this child's death. A report was sent to the Director on May 30, 2003.

Case # 4 **DOB January 2001** **DOD July 2002**
Age at death: 1-1/2 years
Substance exposed: no
Cause of death: blunt head trauma due to assault
Perpetrator: mother's boyfriend
County: Cook
Narrative: One-and-a-half-year-old child was left in the care of her mother's twenty-three-year-old boyfriend when her twenty-one-year-old mother went to work. The boyfriend called for an ambulance stating that he found the child unresponsive. She was pronounced dead at the hospital. An autopsy revealed serious head injuries. The boyfriend said he may have played too rough with the child, but this explanation was inconsistent with the extent of the child's injuries. The mother and boyfriend were indicated for the child's death. The boyfriend also was charged with murder and the trial has been continued. Since his arrest for murder, the boyfriend has been arrested twice on other felony charges. The deceased was an only child. Prior History: In the seven months prior to this child's death, there were three DCP investigations involving the family. A January 2002 investigation was indicated for inadequate shelter and substantial risk of physical injury because of domestic violence between the child's mother and twenty-two-year-old father. An intact family case was not opened because the mother and father separated, and the mother moved. A June 2002 investigation was unfounded for burns. The child had a small burn to her pinky finger that was consistent with the mother's explanation of being caused when the child touched a clothes iron. A July 2002 investigation for bruises and medical neglect was awaiting supervisor approval to unfound it. The child presented at a hospital with multiple bruises. The investigator consulted with a pediatrician who is an expert in child abuse and showed her photographs of the child. The doctor opined that what was depicted in the photos was an infection, not child abuse. The OIG is conducting a full investigation of this child's death. A report to the director is expected.

Case #5 **DOB May 2002** **DOD July 2002**
Age at death: 2 months
Substance exposed: no
Cause of death: subdural hematoma due to blunt head trauma
Perpetrator: father
County: Cook
Narrative: Two-month-old baby died from blunt head trauma. The baby was being cared for by his twenty-one-year-old father. The father confessed to becoming upset with the baby when he wouldn't drink his bottle. He said he violently bounced the infant up and down in his bouncy seat and threw the baby into it. By all accounts, prior to this incident the father was a hands-on loving caretaker. The father

was indicated for the baby's death. He also was charged with first-degree murder. The trial was recently continued. Prior History: The father, who was a ward. had repeatedly asked for his case to be closed, and he refused to comply with services. He was emancipated in September 2000, however, DCFS did not close his case until October 2001. The baby's twenty-year-old mother was never involved with the Department. The OIG reviewed records in this case.

Case # 6 **DOB April 2001** **DOD July 2002**
Age at death: 15 months
Substance exposed: no
Cause of death: suffocation
Perpetrator: mother
County: Winnebago
Narrative: Fifteen-month-old child died after being suffocated by her mother. The twenty-three-year-old mother confessed to smothering the child by holding her hand and a blanket over the child's nose and mouth. The mother was indicated for the child's death. She also was charged with first-degree murder. Her two surviving children, ages 3 and 8, were placed in foster care. The oldest was returned to her father's custody in July 2003. Prior History: This family had been the subject of three previous investigations of environmental neglect in February 2000, August 2000, and March 2002. The August 2000 and March 2002 reports were indicated and the Department attempted to provide services to the family, but the mother did not respond. In May 2002 the hotline received a report that someone was intentionally making the deceased ill with ipecac syrup, and the child had been hospitalized several times as a result. The mother placed blame on the maternal grandmother who was indicated for poisoning the child. After the child's death, the mother admitted to poisoning the child so she would get sick and cuddle with her. The OIG is conducting a full investigation of this child's death. A report to the director is expected.

Case # 7 **DOB March 1987** **DOD August 2002**
Age at death: 15 years
Substance exposed: no
Cause of death: hemorrhagic shock from sharp force injury of aorta due to stab wound to back
Perpetrator: DCFS ward
County: Winnebago
Narrative: Fifteen-year-old child was stabbed in the back by his grandparent's neighbor, an eighteen-year-old DCFS ward. The teenagers were preparing for a back-to-school party at the deceased's grandparents' house. Witnesses told police that the teenagers were trading insults with each other when the ward ran into her foster home, grabbed a knife, and stabbed the fifteen-year-old in the back, striking a major artery. The ward was convicted of first degree murder in April 2003 and sentenced to twenty years in prison. Prior History: The ward's family came to the attention of DCFS in 1981 because of neglect. The ward and her sister entered foster care in June 1986. In June 1987, the sisters were placed together in the foster home the ward was living in at the time of the murder. The ward graduated from high school in June 2002. There was talk about her going to college. She was described as a typical teenager and did not have a record of delinquency. Her foster parents remain in touch with her. The OIG reviewed records in this case.

Case # 8 **DOB November 1998** **DOD August 2002**
Age at death: 3-1/2 years
Substance exposed: no
Cause of death: staphylococcal sepsis resulting from a wound infection due to Battered Child Syndrome
Perpetrators: mother and stepfather

County: Ogden, Utah
Narrative: Three-and-a-half-year-old child died as a result of multiple beatings that resulted in an overwhelming bacterial infection. At the time of her death she had multiple bruises, open wounds, internal injuries, and broken bones. Because of her physical condition, her body's ability to fight off infection was limited. The twenty-six-year-old mother and thirty-year-old step-father pleaded guilty to murder and are serving a sentence of five years to life. Prior History: There was a hotline report on this child in Illinois in February 2002. A worker at a shelter where the family was staying called the hotline and reported that mom was slapping and hitting the child and pinching her nose and ears. The investigation was unfounded after the reporter stated she did not have any personal suspicion of abuse or neglect, but made the report based on information given to her by another client in the shelter. None of the clients interviewed at the shelter had observed any abuse and the child did not show any evidence of abuse. The credibility of the woman who reported the abuse to the shelter worker was questioned as she and the mother had recently had an argument. The OIG reviewed records in this case.

Case # 9 **DOB June 2002** **DOD September 2002**
Age at death: 2-½ months
Substance exposed: no
Cause of death: drowning
Perpetrator: maternal grandmother
County: Cook
Narrative: Two-and-a-half-month-old infant was taken by ambulance to the hospital where he was pronounced dead on arrival. The infant was found cold and wet by paramedics who arrived after being called by the forty-five-year-old maternal grandmother who said she found the infant unresponsive. A medical exam revealed bruising to the upper abdomen, supra pubic area, and right arm. It is believed the maternal grandmother drowned the infant by pressing down on his chest into the water. The grandmother admitted to using heroin and cocaine before her grandson was left in her care. She could not account for how the death occurred. The grandmother was indicated for the child's death. She also was charged with first-degree murder and is awaiting trial. Prior History: This family has a long history with the Department. The mother of the deceased and her sibling entered DCFS custody in 1991 for neglect. The mother was a ward from November 1991 until May 2000 when she was emancipated. The grandmother's parental rights were terminated on her other child, who was still in DCFS custody at the time of this child's death. The mother of the deceased had two unfounded reports, one for neglect and one for abuse, within a year of this child's death. The OIG reviewed records in this case.

Case #10 **DOB June 1985** **DOD November 2002**
Age at death: 17 years
Substance exposed: unknown
Cause of death: gunshot wound of the face
Perpetrator: stepfather *
County: Cook County
Narrative: Seventeen-year-old girl was shot and killed by her stepfather. During a discussion about sexually transmitted diseases, the stepfather removed his handgun from a firebox that was under his bed, removed the magazine from the weapon, and demonstrated what would happen to any boy who hurt his daughters. The gun accidentally discharged, striking his daughter in the face. No criminal charges were filed. Prior History: There was an unfounded DCP investigation involving the family. In August 2002, an anonymous reporter called the hotline alleging that the thirty-three-year-old mother and her three daughters, ages 10, 15, and 17, had gotten into an argument and the mother threatened to stab the girls. DCFS unfounded the investigation after interviewing the mother, girls, family friend, and pediatrician. All reported that the children were well cared for. The mother and seventeen-year-old admitted recently getting into an argument after the mother asked her daughter to clean up and the daughter refused. The OIG conducted a full investigation of this child's death. The investigation did not result in a report to the

director. * Note: The Cook County Medical Examiner's Office classifies any death caused by a gun a homicide, when the person handling the gun knows that it can kill someone.

Case #11 **DOB November 1997** **DOD November 2002**
Age at death: 5 years
Substance exposed: no
Cause of death: multiple injuries due to blunt trauma due to child abuse
Perpetrator: mother's boyfriend
County: Cook
Narrative: Three siblings ages 5, 6, and 8, were left in the care of their mother's thirty-five-year-old boyfriend, along with the boyfriend's three-year-old child. The twenty-nine-year-old mother returned to find the five-year-old child unresponsive and took him to the hospital. The children reported that the boyfriend beat the child with a belt, rope, and brush for urinating on himself. After the beating the boyfriend put the child in a bathtub and submerged his head until he was no longer breathing. The boyfriend then took the child out of the tub, dressed him, and placed him on the floor unconscious. The child died the next day. At autopsy the child had multiple injuries to his head, face, chest, abdomen, back, hips, buttocks, legs and arms, as well as several areas of internal injury. Some of the injuries were old. The boyfriend was indicated for the child's death. The child's mother was indicated for abuse to the deceased and substantial risk of physical injury to his siblings because she knew her boyfriend had abused the child in the past, but left her children alone with him anyway. The boyfriend has been charged with first degree murder. The trial is scheduled to begin in January 2004. Prior History: This family came to the attention of the Department in December 2001 when the hotline received a report that the children were living in a motel missing meals and wearing dirty clothes. The mother and her boyfriend were indicated for substantial risk of physical injury and the mother was also indicated for environmental neglect and inadequate food. An intact family case was open until July 2002. Following the child's death, his two siblings were taken into protective custody and placed with their maternal grandmother with whom they continue to reside. The boyfriend's child was returned to her mother's care. The OIG reviewed records in this case.

Case #12 **DOB September 2002** **DOD December 2002**
Age at death: 2 months
Substance exposed: no
Cause of death: closed head injury
Perpetrator: father
County: St. Louis, Missouri (death)
St. Clair (residence)
Narrative: Two-month-old infant was taken to the hospital with a head injury. She died two weeks later. Her twenty-two-year-old father said he found the infant on the floor unresponsive after leaving her on the couch. The infant's injuries were inconsistent with a fall from a couch. She had severe retinal hemorrhaging, a symptom of Shaken Baby Syndrome. The father and mother were indicated for the death of the child. The father also was charged with murder and is awaiting trial. The infant's three siblings were taken into custody and placed with a relative. Their twenty-seven-year-old mother is working toward their return. Prior History: The mother's first contact with the Department was during her childhood when her sisters were sexually abused. As a parent, the mother and her boyfriend came to the attention of the Department in October 1999 when the mother's four-month-old infant had a bruise on her face and the mother had no explanation for it. An investigation of the bruise was unfounded because no clear perpetrator or cause of the bruise could be determined. Later that month, doctors found several rib fractures on the four-month-old baby and the children were taken into custody. The mother was indicated for bone fractures and substantial risk of physical injury. The children were returned home in December 1999. In September 2002, the mother called the hotline requesting assistance because her apartment was infested with mice and other bugs, and had significant leaks, peeling paint, and mold. A

hotline report was indicated for environmental neglect. The children temporarily stayed with a maternal relative and an intact family services case was opened. This case was open at the time of the infant's death. The OIG is conducting a full investigation of this child's death. A report to the director is expected.

Case #13 **DOB April 2002** **DOD December 2002**
Age at death: 8 months
Substance exposed: no
Cause of death: subdural hematoma due to blunt head trauma
Perpetrator: babysitter
County: Cook
Narrative: Eight-month-old baby died after being brought to the hospital with severe head injuries. A fifty-eight-year-old babysitter, who lived in the same building as the mother and her eight-month-old and six-year-old daughters, was caring for the baby. The babysitter said the child fell down the stairs in her walker, but this explanation was inconsistent with the child's injuries. The babysitter was indicated for the baby's death. She did not have a prior history with DCFS. There have been no criminal charges filed in this case. Prior History: The babysitter did not have a prior history with DCFS. At the time of this baby's death there was a pending DCP investigation on the thirty-three-year-old mother's twenty-two-year-old boyfriend. The mother called the police after her boyfriend hit her six-year-old daughter with an electrical cord on her leg. The boyfriend was arrested and charged with domestic battery and the mother and boyfriend (father of the deceased) separated. The boyfriend was indicated for cuts, welts, and bruises to the six-year-old. The OIG reviewed records in this case.

Case # 14 **DOB June 1996** **DOD December 2002**
Age at death: 6-1/2 years
Substance exposed: no
Cause of death: blunt trauma to the abdomen and hypothermia
Perpetrator: mother's boyfriend
County: Cook
Narrative: Six-and-a-half-year old child was severely beaten by her twenty-six-year-old mother's twenty-four-year-old boyfriend and left outside in the snow for several hours. The boyfriend and mother were indicated for the death of the child. The boyfriend was charged with first degree murder and is scheduled to appear in court in January 2004. Prior History: Two months earlier, a local Public Health office had called the hotline to report bruises on the mother and two black eyes on the child. The hotline report also noted that a health worker overheard the boyfriend tell the child in Spanish that if anyone asked her about her eyes, she should say that she fell down the stairs. The family eluded the Department investigator and the investigation was closed after 60 days. Soon after the closure, another report was called into the hotline. This time police and medical personnel called after a knife fight between the boyfriend and his brother because both the mother and child had injuries when the police arrived to break up the fight. The second abuse investigation was pending at the time of the child's murder. The OIG conducted a full investigation of this child's death. A report was sent to the Director on June 5, 2003.

Case #15 **DOB August 1985** **DOD February 2003**
Age at death: 17-1/2 years
Substance exposed: unknown, however, there is a history of maternal substance abuse
Cause of death: gunshot wound to head
Perpetrator: non-caretaker
County: Milwaukee County, Wisconsin
Cook (case management)
Narrative: Seventeen-year-old ward ran away from his foster home at the end of January 2003 because he believed the police were looking for him. He went to Milwaukee where family members were living. A

relative found his body on the porch of a drug house with a gunshot wound to the head. The gunman was arrested and convicted of reckless homicide in June 2003. He was sentenced to fifteen years in prison and ten years supervision following his release. Prior History: The thirty-nine-year-old mother of the deceased has given birth to ten children. The family came to the attention of DCFS in May 1990 when the mother was indicated for medical neglect. Over the next seven years she gave birth to three substance-exposed infants and was indicated for neglecting her children. The children entered foster care in May 1997. Five children have been adopted, two are in subsidized guardianship, and two entered private custody agreements with relatives right after their births. The OIG reviewed records in this case.

Case # 16 **DOB April 1999** **DOD February 2003**
Age at death: 3-1/2 years
Substance exposed: no, however, there is a history of parental substance abuse
Cause of death: subdural hematoma as a result of blunt head trauma
Perpetrator: babysitter
County: Cook
Narrative: Three-year-old ward, placed in traditional foster care, was taken to a local hospital after suffering multiple injuries. The ward was left in the care of a weekend babysitter while her foster mother went out of town. The babysitter reported the child fell down a flight of stairs. The child died from her injuries eight days later. The babysitter's explanation of what happened to the child was inconsistent with the extent of the child's injuries, and the death was ruled a homicide. The babysitter was indicated for the death of the child. The Illinois State Police are investigating this child's death. There have been no criminal charges filed. Prior History: The three-year-old child was the youngest of four siblings. The family became involved with DCFS in September 1998 when a case was opened for intact family services because of allegations of inadequate food and environmental neglect by the thirty-four-year-old mother and thirty-six-year-old father. Both parents had a history of abusing drugs. The mother died of a heroin overdose in March 2001. The father was arrested for endangering the lives of his children because of their environment. Following the mother's death, the children were moved between relatives and the father was undomiciled. The Department took custody of the children in July 2001 when they could no longer remain with relatives. The four girls were placed in the same foster home in November 2001 where they remained until the death of the three-year-old child. Victim sensitive interviews were conducted with the three older girls after the death of their sister. They reported corporal punishment by their foster mother and the babysitter and were not returned to the foster mother's care. The foster mother was indicated for substantial risk of physical injury to the girls. The siblings currently reside together in another foster home and are moving towards adoption. The OIG reviewed records in this case.

Case # 17 **DOB May 1987** **DOD March 2003**
Age at death: 15 years
Substance exposed: no
Cause of death: multiple gunshot wounds
Perpetrator: Non-caretaker
County: Cook
Narrative: Fifteen-year-old ward was shot while in a car with a fellow gang member. The fellow gang member was killed at the scene. The ward died in the hospital two days later. A twenty-two-year-old gunman has been charged with murder and is awaiting trial. Prior History: The deceased came to the attention of the Department in June 1988 when he was taken into protective custody. He was placed in the home of a relative until October 1988 when he was returned to his mother's care. He reentered the custody of DCFS in July 1992 and was placed with his maternal grandmother who assumed subsidized guardianship for him from May 1999 to August 2001. In August 2001, he reentered DCFS custody and began a history of frequently running from his placements. At the time of his death, he had been on run for twelve days. A missing person's report had been filed. The OIG conducted a preliminary review of this ward's death.

Case # 18 **DOB March 1983** **DOD March 2003**
Age at death: 20 years
Substance exposed: unknown
Cause of death: gunshot wound to the head lacerating brain
Perpetrator: Non-caretaker
County: Cook
Narrative: Twenty-year-old ward was outside his girlfriend's house when he was shot in the head around 11:00 p.m., allegedly by rival gang members. Two offenders have been arrested and are currently awaiting trial. Prior History: This family has been involved with the Department since 1988. The forty-one-year-old mother has had six children, all have been in foster care. The deceased was in foster care three times; his last entry was in April 1998. He lived primarily with one relative, however, he served several months in juvenile detention in 2000 and again in 2002. The ward was enrolled in school, but he did not attend. The OIG reviewed records in this case.

Case #19 **DOB June 2002** **DOD March 2003**
Age at death: 9 months
Substance exposed: no
Cause of death: craniocerebral blunt trauma
Perpetrator: babysitter
County: St. Clair
Narrative: Nine-month-old infant was transported to the hospital in respiratory distress and died there thirty minutes after being admitted. An autopsy revealed numerous skull fractures and brain hemorrhaging. A twenty-two-year-old friend and neighbor of the mother, who watched the child for thirty minutes on the day of his death, confessed to throwing the child to the ground in frustration over his crying. The babysitter was indicated for the child's death and charged with first-degree murder. She is scheduled for a fitness hearing in January 2004. Her two children were placed with their maternal grandmother. Prior History: The babysitter had no prior involvement with DCFS. The mother had two prior contacts with DCFS. In July 2001, the mother and her paramour were indicated for inadequate supervision when they left the mother's five-year-old son asleep at home without informing their new roommate. No services were initiated. In August 2002, a report was made to the hotline alleging substantial risk of physical injury to the two-month-old now deceased child. The report alleged that the mother kept the infant outside in extreme heat for six hours at a time on two consecutive days with no shade or shelter to protect him from the sun. The OIG reviewed this investigation. It was unfounded after a thorough investigation that included observing the scene and obtaining the weather data for the days in question.

Case # 20 **DOB October 1989** **DOD March 2003**
Age at death: 13 years
Substance exposed: no
Cause of death: gunshot wound to head
Perpetrator: Non-caretaker
County: Cook
Narrative: Thirteen-year-old was walking down the street with friends one morning when someone drove up in a car and shot the child in the head. The child was transported to the hospital where he was pronounced dead. A thirty-one-year-old gunman was charged with the child's murder after his mother turned him in, and he confessed to shooting the child over a game boy he believed the child took while helping him move. He is currently awaiting trial. Prior History: This family had two contacts with the Department in June 1992 when the parents were indicated for cuts, welts, and bruises and March to September 1996 when an intact family case was open. DCFS had no further contact with the family until February 2003 when the hotline was contacted with an allegation of environmental neglect. An

investigator attempted to meet with the family, but was unable to gain access to their home. The child died prior to the conclusion of the investigation. Upon learning of the death of the child, the Department opened an intact family case to assist the family. Two of the siblings went to live with their father in Milwaukee, Wisconsin. The other four remained at home with their mother. In November 2003, the mother gave birth to a substance-exposed infant. During the DCP investigation, she reported being depressed over the death of her son. The OIG reviewed records in this case.

Case #21 **DOB December 1982** **DOD March 2003**
Age at death: 21 years
Substance exposed: no
Cause of death: massive right hemothorax due to gunshot wound of the right cheek region of the face
Perpetrator: Non-caretakers
County: Macon
Narrative: Twenty-one-year-old former ward of the state was shot in the head when she ran to get help after her boyfriend was shot in the head during a drug deal. The woman's child and her sister's children were in the car at the time of the shooting. Police found the car and the deceased man and woman approximately ten hours later and retrieved the children. The woman's child is residing with the paternal grandmother. Three people have been arrested and charged with murder. They are awaiting trial. Prior History: This former ward entered foster care in January 1991 when her mother neglected her. She had been in an independent living program for the past two years, but had not been making progress in her goal of independence. She was emancipated in October 2002. The OIG conducted a preliminary review of this case.

Case #22 **DOB December 2001** **DOD March 2003**
Age at death: 15 months
Substance exposed: no
Cause of death: subdural hematoma due to blunt force trauma
Perpetrator: babysitter
County: Champaign (death)
Edgar (residence)
Narrative: Fifteen-month-old child was left in the care of his twenty-eight-year-old babysitter who stated the child fell off the couch and hit his head on the carpeted floor. The child's injury was inconsistent with this explanation. Later, the babysitter admitted to slamming the child to the floor, causing the head injury. The babysitter was indicated for the death of the child. She also pleaded guilty to second degree murder and will be sentenced in Edgar County in January 2004. Prior History: The twenty-four-year-old mother came to the attention of the Department in August 2001 when her twenty-seven-year-old boyfriend squeezed her one-year-old child's head, penetrated her with at least two fingers, and dropped the child on the floor. The child was treated for a depressed skull fracture and sexual penetration. The Department took custody of the one-year-old, placed her in a relative foster home, and provided services to the mother. The boyfriend was convicted of aggravated domestic battery and sentenced to ten years. The mother participated in counseling, attended educational courses, and secured employment. The child was returned to her mother's care in July 2002 and her case was closed. The OIG reviewed records in this case.

Case #23 **DOB April 1999** **DOD May 2003**
Age at death: 4 years
Substance exposed: no
Cause of death: peritonitis due to ruptured bowel due to blunt abdominal trauma
Perpetrator: father and his fiancé
County: Cook (death)

DuPage (residence)
Narrative: Four-year-old boy, who suffered from cystic fibrosis, was found unresponsive at his home where he lived with his thirty-one-year-old father, the father's twenty-three- year-old fiancé, and the child's four-year-old and two-year-old half siblings. The father claimed that the child fell down the stairs, but the injuries were not consistent with the explanation, and the death was ruled a homicide. The father and his fiancé were indicated for the death of the child. Their two children were removed from their custody and placed in relative foster care. Police continue to investigate. No one has been charged in the child's death. Prior History: The child first came to the attention of the Department in January 2002 when DCFS investigated and unfounded his twenty-four-year-old mother for medical neglect. In November and December 2002 the Department investigated three reports of bruises to the child. The child told investigators and family that the mother's nineteen-year-old boyfriend hit him with a belt. The mother and her boyfriend were indicated for bruises and substantial risk of physical injury, and the child was taken into protective custody and placed with his aunt. The child's father, who became involved in the child's life in July 2002, petitioned the court for custody, and the child was placed with his father in February 2003. In March and April 2003, DCFS investigated the father three times after receiving reports of bruises on James. All three investigations were unfounded, as the child denied that his father hit him and the father and his fiancé provided explanations for the injuries, including attributing easy bruising to the child's cystic fibrosis. The OIG is conducting a full investigation of this child's death. A report to the director is expected.

Case #24 **DOB July 1999** **DOD June 2003**
Age at death: 3-1/2 years
Cause of death: hemoperitoneum due to blunt abdominal trauma due to child abuse
Perpetrator: mother's boyfriend
County: Cook
Narrative: Three-year-old child died from massive abdominal injuries. The child's five-year-old sibling reported that she witnessed her mother's boyfriend kick and stomp on her sister's stomach. The child's twenty-eight-year-old mother and her thirty-five-year-old live-in boyfriend were indicated for the child's death. The boyfriend also was charged with first-degree murder and is awaiting trial. The two surviving siblings, ages 5 and 8, were released to the custody of their father. Prior History: There was a pending DCP investigation on this family at the time of the child's death. Approximately six weeks earlier, the child's school contacted the hotline to report that the child had two broken arms and bruising to her face, and her mother had not sought medical treatment. The OIG is conducting a full investigation of this child's death. A report to the director is expected.

Case #25 **DOB February 1987** **DOD June 2003**
Age at death: 16 years
Cause of death: multiple gunshot wounds
Perpetrator: unknown
County: Cook
Narrative: Sixteen-year-old ward was shot while on run from his placement. The ward ran from his placement in July 2001 and was murdered in June 2003. While on run, the ward was arrested 10 times by the Chicago police and was charged with gambling, delivery of marijuana to a child under 18, possession of marijuana, criminal trespass, battery/bodily harm, theft of labor/services, and manufacture and delivery of a controlled substance. He also was sought for a homicide that occurred in another district in May 2003. The Chicago police had difficulty identifying him because he used an alias while on run. No one has been charged with his murder. Prior History: The ward entered foster care with his sibling in February 1988 because of his mother's neglect. The children lived with their grandmother for almost thirteen years until her death in 2001. The teenager subsequently was placed with his uncle in California, but he ran from the uncle's home soon after placement. The police quickly found him, but his uncle would not allow him to return to the home. The ward was returned to Illinois and placed in a shelter. He

ran from the shelter in July 2001 and was not seen or heard from by his family. A caseworker assigned to the child's case made regular but unsuccessful attempts to find him by contacting family members and the Chicago police. The teen's use of an alias while on run prevented the caseworker and Chicago police from identifying him. The OIG reviewed records in this case.

Deaths in Which the Manner of Death Was Ruled Suicide by the Medical Examiner or Coroner's Office

Case #26 **DOB October 1987** **DOD December 2002**
Age at death: 15 years
Substance exposed: no
Cause of death: hanging by the neck
County: Tazewell
Narrative: Fifteen-year-old ward hanged himself three weeks after his birthday, while in his fifth foster home placement. He had just moved into this home after a short stay in another foster home. Prior to these two recent placements, the ward had lived with a foster family for two years. He did not want to leave this foster family, a two-parent family with three older biological children. The teenager had come into state custody when he was three years old. He had been severely burned in a house fire in which his mother and infant sister perished. A dependency petition was filed when the staff in the burn unit determined that his grandmother, who had cognitive disabilities, would not be able to provide adequate care for the recovering child. Following discharge from the burn unit, the child was placed in a specialized foster home for six months and then placed in the care of his grandmother under DCFS guardianship. During his preteen years, the youngster spent a week during the summer at the Illinois Fire Safety Alliance Camp. The youngster was in special education classes and his grandmother received homemaking and transportation services from the Department of Rehabilitative Services. In addition, DORS assisted the grandmother by helping her grandson with his schoolwork. In the fifth grade he missed school when he underwent surgery to repair stretching skin graphs and muscle tissue and developed an infection following the surgery. His grandmother's intellectual limitation and her difficulties in assessing problems and making appropriate decisions became a hindrance to the ward's care when she refused services or became hostile to the provider agencies. In August 2000, the reluctant twelve-year-old was removed from the custody of his grandmother. He was behind in school and had poor social skills. At the time, the youngster was still sleeping in the same bed as his grandmother. Shortly after the placement, the youth was discovered to have used "pokeman" cards to bribe a four-year-old foster child to engage in oral sexual contact. The twelve-year-old youngster admitted the sexual offense and was charged with criminal sexual abuse. He was placed on 18 months probation and attended court ordered sexual offender services. He was not allowed to attend his burn camp, was prohibited from attending junior high and high school functions without additional supervision and lost the opportunity to join his older foster brothers in weekend night activities because of an early curfew. He grew more and more isolated. Simultaneously, the foster parents were asked to consider adoption or guardianship of the ward. The family felt pressured by the agency requesting these permanency goals. The ward's school was informed of his sexual offense, and the foster mother voiced exhaustion with all of the restrictions placed on her and her family because of his SACY (Sexually Aggressive Children and Youth) requirements. In addition, her mother became terminally ill. The family asked for the teenager's removal. The youngster always missed his grandmother and had heard that the court ruled that he could not return to his grandmother. A few weeks before his suicide, his grandmother told him about a young girl's suicide. The OIG reviewed records in this case.

Deaths in Which the Manner of Death Was Ruled Undetermined by the Medical Examiner or Coroner's Office

Case #27 **DOB March 2001** **DOD July 2002**
Age at death: 16 months
Substance exposed: no
Cause of death: drowning
County: Cook
Narrative: Sixteen-month-old child was found by his sibling floating face down in the family's backyard pool. Paramedics were called. The child's twenty-six-year-old mother removed him from the pool with help from a friend who was a registered nurse. The nurse performed CPR until rescue workers arrived. Paramedics also tried to revive the child while he was transported to the hospital where he was pronounced dead. Prior History: This family came to the attention of the Department in May 2001 when the forty-year-old father of the deceased held the dull side of a knife to his oldest daughter's throat and beat her with a belt. The two oldest daughters were residing with their father, step-mother, and four half siblings. The father was indicated for substantial risk of physical injury. An order of protection was issued for the two oldest children in the home, then ages twelve and ten. They were taken into custody and placed with their maternal grandmother. The girls' half siblings remained in the home in the custody of their mother. The court issued a no contact order for the father regarding all of the children and he moved out of the family home. The judge also ordered the father to engage in services, which he completed. In April 2002, the father was allowed to move back into the family home with his wife and their four children. The oldest daughter remains in foster care with her maternal grandmother with a goal of guardianship. The other daughter returned home to her father in March 2003. The OIG reviewed records in this case.

Case #28 **DOB August 2002** **DOD October 2002**
Age at death: 2 months
Substance exposed: unknown
Cause of death: undetermined
County: Cook
Narrative: Two-month-old infant was found unresponsive while co-sleeping with her parents. The infant was taken to the hospital where she was pronounced dead. The child reportedly had health problems since birth. A DCP investigation was initiated following the child's death because the father was living in the home in violation of a previous safety plan. The safety plan was put in place because of an indicated finding against the father for sexual molestation of his sixteen-year-old step-daughter, no longer living in the home. The DCP investigation was indicated against both parents for substantial risk of sexual abuse. The parents agreed to a safety plan whereby the father would move out of the home and have no unsupervised visitation with the surviving siblings, ages 4 and 6. An intact family case is open. Prior History: This family came to the attention of DCFS in July 1997 when the father disclosed that he fondled his sixteen-year-old step-daughter. He was remorseful and moved out of the home. An intact family case was open from July 1997 to January 1999. A second case was open from March 2001 to October 2001 when the father's nineteen-year-old son, who lived with the family, admitted to penetrating his three-and-a-half-year-old half-sibling on two occasions. The OIG reviewed records in this case.

Case #29 **DOB December 2000** **DOD July 2002**
Age at death: 2 years
Substance exposed: no
Cause of death: drowning
County: Cook
Narrative: Two-year-old child was found by her nineteen-year-old father in the bathtub unresponsive. She was taken to the hospital where she was pronounced dead. The child's nineteen-year-old mother,

who is a ward, left the child in the father's care when she went to work. The child had unexplained bruises at the time of her death. Prior History: The Department became involved with the mother when she was six, following an indicated report of inadequate supervision. The mother was placed in the private guardianship of a family friend. The mother entered foster care in 1995 when her guardian was indicated for cuts, welts, and bruises and substantial risk of physical injury to her. At the time of the child's death, the mother was in an independent living program and was living in an apartment with her daughter. The mother was compliant with the expectations of the program. She worked full time and hoped to enroll in college. At the time of her child's death, the mother was pregnant with a second child by the same father. She terminated the pregnancy. The mother is still a ward and remains in independent living. The OIG reviewed records in this case.

Case #30 **DOB April 2002** **DOD March 2003**
Age at death: 10 months
Substance exposed: no
Cause of death: bronchopneumonia due to drowning
County: Cook
Narrative: Ten-month-old baby died after living on life support for fifteen days. The baby and his three siblings were left by their forty-four-year-old father in the care of a paternal uncle who was living in the home. Upon his return, the father found the uncle asleep and the baby partially submerged in an industrial mop bucket that contained water with Lysol. Prior History: There was an intact family case open at the time of this baby's death. The case was opened following a July 2002 report of medical neglect by the father to a sixteen-year-old son diagnosed with cerebral palsy, seizure disorder, and mental retardation. The child was placed in a residential care facility by voluntary agreement of the child's father. The child had a trust fund from a medical malpractice lawsuit and, he was being followed by the probate court. By order of the probate court, the uncle was not supposed to be living in the family's home because of his history of substance abuse. The OIG reviewed records in this case.

Case #31 **DOB November 2002** **DOD March 2003**
Age at death: 4 months
Substance exposed: no
Cause of death: undetermined
County: Cook
Narrative: Four-month-old infant was found unresponsive by his twenty-five-year-old father. The infant had been napping on an adult bed with his one-year-old sibling. The father contacted 911 and the infant was transported to the hospital where he was pronounced dead. The mother was not home at the time. This was the thirty-one-year-old mother's second child to die. In May 1995, a five-month-old infant died. His death was ruled a SIDS death. This was changed to undetermined following this second infant's unexplained death. Because of the suspicion surrounding two unexplained infant deaths, the parents were indicated for substantial risk of physical injury to the three surviving children in their care, ages 1, 3, and 4, and an intact family case was opened. Prior History: The family had a pending DCP investigation at the time of the infant's death. In February 2003, the hotline received a report of medical neglect to a four-year-old child in the home. The child was taken to the hospital because he had been complaining of seeing bugs. Hospital staff were concerned that the child might be experiencing seizures and wanted him tested further. The family had not shown up for testing. The investigation was ultimately unfounded because the doctor who ordered the testing said they were not emergency procedures and missing the appointments would not be considered medical neglect. The family missed the appointments because they were in the process of changing insurance coverage. The OIG reviewed records in this case.

Case #32 **DOB November 2003** **DOD May 2003**
Age at death: 6 months
Substance exposed: yes, cocaine and opiates
Cause of death: undetermined
County: Cook
Narrative: Six-month-old infant was found unresponsive by her thirty-six-year-old mother in the bed that they shared. The child regularly slept with her mother in her mother's bed. There was no crib in the home. The mother was indicated for death by neglect. The infant was supposed to be taking cold medication to help her breathe, but the mother was not giving it to her. Then infant's siblings entered foster care after the infant's death as mom was not participating in services to address her substance abuse. The children are placed together with a relative. Prior History: The family came to the attention of the department in September 1999 when the mother gave birth to a substance-exposed infant. The mother was indicated for substance misuse and an intact family case was open from October 1999 to April 2001. In November 2002 the mother gave birth to a second substance-exposed infant. The mother was indicated for substance misuse and an intact family case was opened in January 2003. When the investigator and intact family worker went to the home to introduce the worker, they found the children, ages 2 months, 3, 10, and 12, home alone. The ten and twelve-year-old children should have been in school. The mother was indicated for inadequate supervision. The OIG is conducting a full investigation of this child's death. A report to the director is expected.

Case #33 **DOB March 2003** **DOD May 2003**
Age at death: 2 months
Substance exposed: yes, cocaine
Cause of death: undetermined
County: Cook
Narrative: Two-month-old infant was pronounced dead after being taken to the medical examiner's office by paramedics. The infant's thirty-year-old mother left home around 8:30 at night to try to get some money for milk. She left the infant and a one-year-old child in the care of their twelve-year-old brother. The brother laid everyone to sleep on the floor, with the infant on one side and the one-year-old on the other, and covered them with a sheet. Around 3:00 in the morning the child awoke and found the infant not breathing. He brought the baby to a man with whom the family lived and told him something was wrong with the infant. The man said the baby was fine and went back to sleep. The twelve-year-old stayed awake and rocked the baby and prayed until the mother returned home around 5:00 in the morning. When the mother returned home, she ran out to get help. When the paramedics arrived, they found the baby in rigor mortis and transported her to the medical examiner's office. The mother was indicated for death by neglect. The surviving siblings were taken into custody. They are each placed with a relative. Prior History: This family first came to the attention of the Department in March 2002, when the mother was indicated for substance misuse when her second child was born cocaine positive. An intact family case was open from April 2002 to August 2002 when it was closed because the mother was not participating in services. The case was reopened in October 2002 when the mother was indicated for inadequate supervision of her children because she was leaving them with her ninety-three-year-old great-great-grandmother who could not care for the children. In March 2003 the mother was indicated for substance misuse when she gave birth to the deceased, her second substance-exposed infant. The intact family case was still open at the time of the infant's death. The OIG is conducting a full investigation of this child's death. A report to the director is expected.

Case #34 **DOB April 2003** **DOD May 2003**
Age at death: 1 month
Substance exposed: no
Cause of death: undetermined
County: Cook
Narrative: One-month-old infant was found unresponsive by his thirty-one-year-old father. The infant and father were napping in the same bed. The infant was transported by ambulance to the hospital where he was pronounced dead. The Cook County Medical Examiner's Office was unable to conduct a routine scene investigation because the family moved and did not cooperate with investigators. Prior History: The mother came to the attention of the Department in August 2000 when she called the hotline stating she intended to enter the hospital to get treatment for depression, and she had no one to care for her three sons. The Department took custody of two of the boys and the third was sent to stay with his father in Virginia. The two sons were placed in a foster home and then with a maternal relative. The children were returned to the mother's care in October 2001. DCFS continued to monitor the family and were actively engaged in therapy and other services with the Department. The family's case was closed in November 2003. The OIG reviewed records in this case.

Deaths in Which the Manner of Death Was Ruled Accident by the Medial Examiner or Coroner's Office

Case #35 **DOB August 2001** **DOD July 2002**
Age at death: 10 months
Substance exposed: no
Cause of death: drowning in a sump pump well
County: Sangamon
Narrative: Ten-month-old baby was found by his mother face down in a sump pump well containing a few inches of water. The well was located in the basement of his grandmother's townhouse where the infant, his twenty-two-year-old mother, and two-year-old sister had been sleeping. The cover to the sump pump had been broken previously and repaired. The repair failed when the child crawled on top of it. Prior History: There was a pending DCP investigation at the time of the child's death. In June 2002 a report was made alleging substantial risk of physical injury to the mother's three children after a shelter, where the family was staying, reported that she had hit her six-year-old daughter in the mouth. The report was indicated based on shelter staff reports that the mother was verbally abusive to her children and the mother's admission that she hit her daughter in the mouth for talking back. The six-year-old, who primarily lived with her father, went back to the father and the mother and the two other children moved in with the grandmother. The family was monitored through August 2002 and the mother was given community referrals for parenting classes. She was not interested in further referrals for counseling or supportive services. The OIG reviewed records in this case.

Case #36 **DOB June 2002** **DOD July 2002**
Age at death: 1 month
Substance exposed: no
Cause of death: asphyxia due to overlay
County: Cook
Narrative: One-month-old infant who was sleeping in the same bed as her nineteen-year-old mother was found unresponsive in the morning. The mother was a ward of DCFS who was living in a group home with her daughter. The house manager called 911 and the infant was transported to the hospital where she was pronounced dead. The house manager reported seeing the baby in bed with the mother, but did not know it was dangerous. A DCP investigation of the infant's death was unfounded. Prior History: The mother had been a ward of DCFS since May 1986 when her own mother was indicated for inadequate supervision. The ward had numerous placements. She became involved in the Teen Parenting Services

Network when she became pregnant with the deceased. She had lived in the group home for seven months. According to the mother and workers at the group home, the mother usually placed the baby in the crib near her bed. The mother's case was closed in November 2002 when she reached majority. She had no other children at that time. This case was reviewed as part of a larger investigation on infant sleep safety. A report entitled Child Death Investigations Involving Infant Sleep Safety, OIG #032,162, was sent to the Director on June 30, 2003.

Case #37 **DOB March 2002** **DOD July 2002**
Age at death: 4 months
Substance exposed: no
Cause of death: asphyxia due to overlay
County: Cook
Narrative: Four-month-old infant was found unresponsive in bed by his eighteen-year-old mother who is a ward of DCFS. The mother was taking the infant and his two-year-old sister to see their biological father who was incarcerated in a downstate prison. By the time the family arrived downstate they had missed visiting hours and could not get a bus back home until the next day. A woman the mother met on the bus allowed the family to stay overnight in her apartment. The mother slept with both her children in a full-size bed. Prior History: The mother has been a ward of the Department since February 1991 when her family was found to be living in unsafe conditions because of her mother's drug use. The mother was admitted to the Teen Parenting Program in September 1999. Two weeks prior to the death of her child, the mother and her two children had moved to a new transitional living facility. The mother's case is still open with the Department. This case was reviewed as part of a larger investigation on infant sleep safety. A report entitled Child Death Investigations Involving Infant Sleep Safety, OIG #032,162, was sent to the Director on June 30, 2003.

Case #38 **DOB June 2002** **DOD August 2002**
Age at death: 1-½ months
Substance exposed: no
Cause of death: asphyxia due to soft material suffocation
County: Lake
Narrative: Six-week-old infant was discovered unresponsive by his godmother lying on his stomach on a queen size bed. The infant had been babysat the night before by the godmother's fifteen-year-old daughter who put the baby to sleep face down. The infant's sixteen-year-old mother was not present at the time. Prior History: At the time of the infant's death, the mother was a child on an intact family case opened on the forty-one-year-old maternal grandmother of the infant. The case was opened in March 2002 because of the grandmother's substance abuse. The intact family worker referred the grandmother to substance abuse treatment. The teenager was taken to prenatal appointments and enrolled in a teen parent program. The grandmother continued to use drugs and following the infant's death, the sixteen-year-old went to live with her maternal aunt and her ten-year-old sister went to live with her maternal grandmother, who obtained guardianship of her in February 2003. This case was reviewed as part of a larger investigation on infant sleep safety. A report entitled Child Death Investigations Involving Infant Sleep Safety, OIG #032,162, was sent to the Director on June 30, 2003.

Case #39 **DOB September 1998** **DOD August 2002**
Age at death: 3-1/2 years
Substance exposed: no
Cause of death: drowning in a swimming pool
County: Will
Narrative: Three-and-a-half-year-old child died in the hospital a day after being resuscitated from drowning in a swimming pool at his day care facility. The child got out of the house, went to the pool approximately 25 feet away, climbed the stairs, entered the gate, and went into the pool. The caretaker

was busy with another child at the time. The caretaker noticed the child was gone and that the gate to the pool was open. She ran to the pool and saw the child floating face down in the water. She pulled the child out and attempted CPR while a twelve-year-old in the home called 911. The day care provider was indicated for the child's death by neglect and is no longer licensed to provide day care. Prior History: The day care provider first came to the attention of the Department in June 2002 when the parent of an eight-year-old who attended the day care from June 1998 to April 2002 contacted the hotline. The parent reported that his son told him that the caretaker would duct tape his mouth and tie his hands with a rope when he was making too much noise. The Department unfounded the allegation after the investigation. The caretaker admitted to duct taping the child on one occasion when he was dressed up as a hotdog and she showed the investigator a photo of the child dressed up. There was no evidence the child had been duct taped or tied up on any other occasion. The caretaker was a friend of the child's mother and had sided with the mother in the parents' divorce and custody case. The mother denied that the caretaker had ever hurt either of her children. The OIG reviewed records in this case.

Case #40 **DOB November 1991** **DOD August 2002**
Age at death: 10-1/2 years
Substance exposed: no, however, mother has a history of substance abuse
Cause of death: multiple injuries due to train striking pedestrian
County: Cook
Narrative: Ten-and-a-half-year-old was struck and killed by a Metra train while on his way to football practice. The child ducked under a crossing gate after the Southbound train went by. He apparently didn't see the Northbound train coming and it hit him. Prior History: This family came to the attention of DCFS in 1995 when an intact family services case was opened. The case was reopened twice for preventive services in October 2001 and April 2002. In both cases Norman funds were provided to the family. The maternal grandmother made a hotline report the day before the child died alleging inadequate supervision of the child and his three siblings because of the mother's drug use. The child, his siblings, and his mother were interviewed on the day the child died. The mother admitted relapsing in her substance abuse recovery and currently using drugs. The family denied that the children were left alone and said they were left with their mother's friend. During his interview, the child mentioned being late for football practice. The investigation was ultimately unfounded. The maternal grandmother admitted the children had been left with the mother's friend, but that she thought the woman was an inappropriate caretaker. The mother was indicated for substantial risk of physical injury to her surviving sons, ages 6, 5, and 2 because of her drug use. An intact family case was open from October 2002 to November 2003. The OIG reviewed records in this case.

Case #41 **DOB April 2002** **DOD September 2002**
Age at death: 5 months
Substance exposed: no
Cause of death: suffocation
County: Cook
Narrative: Five-month-old infant was found unresponsive by his mother in the babysitters' bedroom after the mother came back from shopping. The infant was found face down with a comforter bunched up around his face. The infant was taken to the hospital by ambulance and pronounced dead. The infant had asthma and was taken to the hospital on two occasions when he stopped breathing. Prior History: A preventive services case was opened on this family in July 2002 when the infant's seventeen-year-old mother brought the infant to the hospital stating she did not want to keep him and only wished to keep her one-year-old daughter. The mother said the baby cried all the time. DCFS opened a case to provide voluntary services. When the case was opened, the family was moving around to the homes of different relatives. While staying at his maternal great grandmother's home, the infant slept on the couch and his mother and sister slept with the grandmother. Shortly after the case was opened, the family left the home of the great grandmother and could not be located by the caseworker. The worker was informed of the

infant's death when she contacted the great grandmother trying to find the family. This case was reviewed as part of a larger investigation on infant sleep safety. A report entitled Child Death Investigations Involving Infant Sleep Safety, OIG #032,162, was sent to the Director on June 30, 2003.

Case #42 **DOB October 1998** **DOD October 2002**
Case #43 **DOB November 2000** **DOD October 2002**
Case #44 **DOB November 2001** **DOD October 2002**
Ages at death: 4 years, 23 months, 11 months
Substance exposed: no
Cause of death: carbon monoxide intoxication due to inhalation of smoke and soot due to a house fire
County: Cook
Narrative: Four-year-old, twenty-three-month-old, and eleven-month-old brothers were killed in a house fire. The fire started in the corner of the living room on the first floor of the house. The cause of the fire was undetermined. It may have started by children playing with matches. The four-year-old was reportedly disciplined a week earlier for playing with fire. At the time of the fire, the seventeen-year-old mother and twenty-one-year-old father were on the second floor of the house. They escaped with minor injuries. Prior History: This family came to the attention of DCFS in November 2000 when a report was made that the mother struck her two-year-old son in the face with a belt causing bruises. The report was indicated for cuts, bruises, and welts and substantial risk of physical injury. An intact family case was open from December 2000 until August 2001. In September 2002, a second report was made alleging environmental neglect, inadequate supervision, and substantial risk of physical injury to the children. The allegation of environmental neglect was indicated because there was no running water in the home. An intact family case was opened and DCFS paid an outstanding water bill and provided beds for the children. The OIG reviewed records in this case.

Case #45 **DOB February 1998** **DOD October 2002**
Age at death: 4-1/2 years
Substance exposed: no, however, mother has a history of substance abuse
Cause of death: asphyxiation due to smoke inhalation in a house fire
County: Winnebago
Narrative: Four-and-a-half-year-old boy was killed in a house fire that destroyed his home. Efforts to rescue him were unsuccessful. He was found dead in his bed. His fifty-seven-year-old adoptive mother survived the fire. The cause of the fire was undetermined. It was suspected that the victim had played with matches or the stove and ignited the fire. The family had a smoke detector, but there was no working battery in it. Prior History: This family has a history with DCFS dating to 1990. The thirty-six-year-old mother of five has a substance abuse problem and has given birth to at least two substance-exposed infants. The deceased was the youngest. He entered foster care at three months of age and was placed with his great-aunt. She adopted him in June 2002. Two of the child's siblings have been adopted and two are in subsidized guardianship. The OIG conducted a preliminary review in this case.

Case #46 **DOB October 2002** **DOD October 2002**
Age at death: 19 days
Substance exposed: no
Cause of death: asphyxia due to overlay
County: Madison
Narrative: Nineteen-day-old infant was found unresponsive by her mother after she awoke on the couch with the infant in her arm. The twenty-four-year-old mother had lain the baby in her bassinet, but the baby was fussy, so the mother laid with her on the couch. The infant was held against the mother's chest in the crook of her arm. The mother was 6'3" tall and weighed 230 pounds. The mother called 911 and the child was transported to the hospital where she was pronounced dead on arrival. A DCP investigation

of the infant's death was unfounded. Prior History: At the time of this infant's death, the family was receiving intensive family preservation services. The intact family case was opened in October 2002, two days prior to the infant's birth, when a report of environmental and medical neglect was indicated on the mother because of the filthy condition of her home and the effect the condition was having on her two-year-old son's asthma. The mother and her two surviving sons, ages 1 and 2, received services through April 2003 when their case was closed. This case was reviewed as part of a larger investigation on infant sleep safety. A report entitled Child Death Investigations Involving Infant Sleep Safety, OIG #032,162, was sent to the Director on June 30, 2003.

Case #47 **DOB October 2002** **DOD November 2002**
Age at death: 1 month
Substance exposed: no
Cause of death: asphyxia due to overlay
County: Cook
Narrative: One-month-old infant was found unresponsive by his mother in a bed where he had been sleeping with his aunt and two cousins. The nineteen-year-old mother was visiting her thirty-one-year-old sister and left the baby in her sister's care for two hours while she went to the store. When the mother returned and found the baby unresponsive, she called 911 and an ambulance transported the baby to the hospital where he was pronounced dead. Prior History: The infant's mother did not have a history with DCFS. The maternal aunt has a history with DCFS dating to June 1992 when she gave birth to a substance-exposed infant. A second substance-exposed infant was born in August 1993 and intact family services were provided. The aunt's five children entered foster care in May 1997 and were placed together in a paternal great-aunt's home. The aunt successfully participated in services and all of the children were returned to her care between July 2000 and December 2001. The OIG reviewed records in this case.

Case #48 **DOB October 2002** **DOD November 2002**
Age at death: 5 weeks
Substance exposed: no
Cause of death: positional asphyxia
County: Jackson
Narrative: Twenty-three-year-old mother fell asleep with her five-week-old baby on the couch and awoke to find the baby between her and the couch. The baby was not breathing. The mother called 911 and the baby was transported to the hospital where she was pronounced dead. Prior History: An intact family case was opened on this family in December 2000 at the request of the local health department because of the mother's lack of follow through on her children's immunizations. The mother had four young children at home, ages 5 months to 4 years. The maternal grandmother was raising a fifth child, who was 6 years old. The mother welcomed services. She was never indicated as a perpetrator of abuse or neglect. The deceased's thirty-two-year-old father was indicated by DCFS in January 2002 for substantial risk of physical injury to the children after he broke into the mother's home and threatened to harm her. The mother was separated
from him and he was in jail at the time of the baby's death. The OIG reviewed records in this case.

Case #49 **DOB June 2000** **DOD December 2002**
Age at death: 2-1/2 years
Substance exposed: no
Cause of death: thermal injuries sustained in an apartment fire
County: Cook
Narrative: Two-and-a-half-year-old child was killed in an apartment fire that started in the rear attic bedroom of the house where the child and her siblings were living with their twenty-three year old mother. A five-year-old sibling who was also in the attic at the time of the fire was taken to the hospital

for minor treatment. The cause of the fire was undetermined. There were no smoke detectors in the home. Prior History: This family came to the attention of DCFS in October 2002 when an allegation of bone fractures was made on the mother of the deceased for breaking her fourteen-year-old niece's thumb during an argument over a telephone. The niece's thumb was only sprained and the maternal aunt was indicated for sprains/dislocations. The OIG reviewed records in this case.

Case #50 **DOB November 2002** **DOD December 2002**
Age at death: 1 month
Substance exposed: yes, cocaine and opiates (methadone)
Cause of death: asphyxiation due to being trapped between the back of the pillows of a couch
County: Cook
Narrative: One-month-old infant was found unresponsive by his mother. The infant had been placed for a nap on top of soft pillows on a small sofa. The infant rolled off the pillows and became trapped between the couch pillows. The mother called 911 and the infant was transported to the hospital where he was pronounced dead. A DCP investigation of the infant's death was unfounded. Prior History: The mother and infant came to the attention of the Department when the infant tested positive for cocaine and opiates at birth. The infant suffered from significant withdrawal symptoms and other problems requiring him to remain hospitalized for two weeks after birth. The child protection investigator allowed the baby to go home with his mother, despite concerns of hospital staff that the mother had not visited the baby since she left the hospital and that no bonding had taken place between the mother and baby. The mother said she had not visited the baby because she was afraid to because the baby had been born with drugs in his system. The mother had supplies for the baby and the maternal grandmother agreed to help care for the infant. The mother had three other children at home, ages 15, 9, and 7 who appeared healthy and well-cared for. The child protection investigator referred the mother for substance abuse treatment and an intact family case was opened, however, the infant died prior to a visit by the caseworker. The intact family case remains open. This case was reviewed as part of a larger investigation on infant sleep safety. A report entitled Child Death Investigations Involving Infant Sleep Safety, OIG #032,162, was sent to the Director on June 30, 2003.

Case #51 **DOB October 2002** **DOD December 2002**
Age at death: 2 months
Substance exposed: no
Cause of death: asphyxia due to overlay
County: Cook
Narrative: Two-month-old infant died while sleeping in a twin size bed with his mother and his sixteen-month-old sibling. The mother awoke to find the infant next to her with his face in her rib cage. The infant's father, who had just come home from work, called 911 and the infant was transported to the hospital where he was pronounced dead. The mother was indicated for death by neglect because during a previous investigation, she had been instructed to get a crib and not allow her baby to sleep on an adult bed. Prior History: This family came to the attention of the Department in November 2001 when a hotline report was made that a three-month-old child had suffered a skull fracture. The mother stated the child had fallen off the bed, but the hospital was skeptical. DCP referred the case to the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC). MPEEC is a program funded and supported by DCFS to provide expert medical review of cases of reported child abuse involving certain types of injuries, including head injuries. Based on the evidence collected during the investigation (medical record, statements, etc.), the MPEEC consultant opined that the injury was consistent with a fall off the bed. The mother was indicated for a skull fracture by neglect. While the death investigation was pending, a hotline call was made alleging that the deceased's sixteen-month-old sibling had burns on his inner thighs that were approximately one month old and that the child had just been brought in for treatment. The mother stated the child had been staying with his paternal grandmother and had sat on a

radiator pipe. The hospital's child protection team opined that the explanation was consistent with the injuries. The parents were indicated for medical neglect and substantial risk of physical injury. The grandmother was indicated for burns by neglect and medical neglect. The child was taken into protective custody and is placed in a traditional foster home. The father has since separated from the mother and is seeking custody of the child. The OIG reviewed records in this case.

Case #52 **DOB September 2002** **DOD December 2002**
Age at death: 3 months
Substance exposed: no
Cause of death: undetermined, probable suffocation
County: Morgan
Narrative: Three-month-old infant was found unresponsive by his mother at 10:25 a.m. The mother had last seen the child at 3:00 a.m. when she fed him and laid him to sleep on his stomach in his bassinet. A coroner's jury ruled the cause of death undetermined and the manner of death accident. A DCP investigation of the infant's death was unfounded. Prior History: The thirty-four-year-old father of the infant has an extensive history of child abuse and neglect reports with the Department dating to 1994. The most recent indicated report was from October 2001. The prior investigations involved children of his with mothers different from the deceased. The twenty-year-old mother was the child subject of an intact family case from May 1981 to November 1985 and again from December 1994 to March 1996. As an adult she had a case open with the Department from June 2002 to September 2002 for preventive services for herself and her one-year-old daughter. The OIG reviewed records in this case.

Case #53 **DOB February 2000** **DOD December 2002**
Age at death: 2-1/2 years
Substance exposed: no
Cause of death: carbon monoxide intoxication due to inhalation of smoke and soot in a house fire
County: Cook
Narrative: Two-and-a-half-year-old boy and his thirty-five-year-old mother were killed in an apartment building fire. Three sisters survived. The fire was believed to have begun in the basement and to be electrical in nature. The family had moved into the second floor apartment a week prior. There was one smoke detector in the apartment, but it did not have a working battery. Prior History: This family first came to the attention of DCFS in October 2002 when a report was made against the mother for substantial risk of physical injury to her 14-year-old daughter. A thorough investigation revealed that while mother was not abusive, spankings were a form of discipline in her home. The 14-year-old was not injured during the spanking. She was spanked because she stayed out late without telling her mother and then lied about where she was. The OIG reviewed the DCP investigation.

Case #54 **DOB May 2000** **DOD December 2002**
Age at death: 2-1/2 years
Substance exposed: no
Cause of death: drowning in a bathtub
County: Cook
Narrative: Two-and-a-half-year-old child with cerebral palsy drowned after being left unattended by his mother in the bathtub. The child was in a bath chair, but hadn't been strapped in. The twenty-three-year-old mother left the child in the bathtub to check on her ten-month-old child who she left unsupervised in the kitchen. The mother called 911 and the child was transported to the hospital where he was pronounced dead. The ten-month-old was allowed to remain in the custody of his father under the condition that the mother not be left unsupervised with the child. The mother and father live together on and off. The family has an open intact family case and both parents are receiving services. Prior History: The family had two hotline reports made on them in June 2002. Both were unfounded. The first report

was generated by the father who called police to report the mother left the children home alone. The mother denied leaving the children home alone and said she left them in their father's care. The mother alleged that the father called police because he was mad at her. The father told the investigator that the mother cared for the children well, but that he wanted her to get therapy for the things that happened to her in the past. The allegation of inadequate supervision was unfounded. The second report alleged medical neglect of the deceased. The mother told a therapist that she was not giving the child his anti-seizure medication because she said it made him sleepy and unable to interact with her. During the DCP investigation, the father reported that he had taken over responsibility for giving the child his medication, and he was administering it regularly to the child. The child was also seeing his doctor and his blood levels were being tested to determine the correct dosage of the medication. The doctor did not report any concerns about the child's medical care. The OIG reviewed records in this case.

Case #55 **DOB March 1992** **DOD February 2003**
Age at death: 10-1/2 years
Substance exposed: no
Cause of death: multiple injuries due to automobile striking pedestrian
County: Cook
Narrative: Ten-and-a-half-year-old ward was hit by an automobile while attempting to cross the street with her foster parent and two others. The ward suffered serious injuries and remained hospitalized until her death two months later. Prior History: The child had been a ward of DCFS since January 1993 when it was discovered that the then nine-month-old infant had rib fractures. In July 1993 the mother attempted to kidnap the child and thereafter had no contact with her. Parental rights to the child were terminated in July 1998. This child was sexually abused in two different foster homes, one in February 1997 and the other in July 2001. The child had been in her present foster home since October 2001. Her foster mother planned to adopt her. The OIG reviewed records in this case.

Case #56 **DOB March 2002** **DOD February 2003**
Age at death: 10 months
Substance exposed: no
Cause of death: asphyxiation due to strangulation
County: Knox
Narrative: Eleven-month-old infant was found unresponsive with binding from a toddler mattress across her neck and arm. The infant had been napping in a toddler bed. She crawled across the room and became tangled in the loose binding on another mattress. The infant was at her babysitter's home. The twenty-two-year-old babysitter was asleep when the infant died. A DCP investigation of the infant's death was unfounded. Prior History: The deceased infant's family had no prior history with the Department, however, the infant's babysitter had an open intact family case while she was babysitting the infant. The babysitter has three of her own children. Her family came to the attention of the Department in 1999. She has had an intact family case open since December 2001.
The OIG is conducting a full investigation of this case. A report to the Director is expected.

Case #57 **DOB September 2002** **DOD February 2003**
Age at death: 5 months
Substance exposed: no
Cause of death: positional asphyxia
County: Madison
Narrative: Five-month-old infant was found unresponsive by his mother between the wall and bottom bed of a bunk bed. The twenty-six-year-old mother had put the child in his pumpkin seat and placed it on the bottom bunk. She did not strap the child into the seat. The mother left the child in the bedroom and took a nap in another room. When she awoke approximately five hours later, she went to check on the child and found him unresponsive between the wall and bed. She ran upstairs to neighbors who called for

assistance. The infant was transported to the hospital where he was pronounced dead. The mother was indicated for death by neglect and substantial risk of physical injury to her surviving three children. Prior History: This family came to the attention of DCFS in November 2001 when a hotline report was made that a six-year-old child was abused. The child's school found bruises on his arms, chest, back, and face from being hit with a belt. The mother was charged with aggravated battery and received two years' probation. She was ordered to comply with DCFS and the abused child was removed from her care. The mother completed services and the child was returned home in April 2002. The Juvenile court case was closed in December 2002. Her DCFS case remains open with a private agency. This case was reviewed as part of a larger investigation on infant sleep safety. A report entitled Child Death Investigations Involving Infant Sleep Safety, OIG #032,162, was sent to the Director on June 30, 2003.

Case #58 **DOB December 2002** **DOD February 2003**
Age at death: 2 months
Substance exposed: no
Cause of death: asphyxia due to overlay
County: Peoria
Narrative: Two-month-old baby was found unresponsive by his twenty-nine-year-old mother. The mother was sleeping with the baby. When she awoke to feed him, she found him cold and unresponsive. The baby was born prematurely at twenty-nine weeks gestation. He was released from the hospital only two weeks prior to his death. The baby had periods of low body temperature. The mother said that doctors instructed her to hold the baby close to her to keep the baby warm. The baby felt cold to her so she took him into bed with her to hold him and keep him warm. A DCP investigation of the child's death was unfounded. Prior History: The family has a history with DCFS dating to September 2000 when the mother and her then-paramour were indicated for cuts, bruises, and welts to the mother's three-year-old child. The children's father was granted custody of the children in court and DCFS opened an intact family case to provide services. The case was closed in December 2001. In August 2002 the mother's husband was investigated for allegations of sexual molestation of her oldest child. The child denied any inappropriate touching occurred and the investigation was unfounded. The older children remain with their father and visit the mother and her husband regularly. The husband has two other children who live with their mothers and regularly visit him and his wife. The OIG reviewed records in this case.

Case #59 **DOB February 1995** **DOD February 2003**
Age at death: 7-1/2 years
Substance exposed: no
Cause of death: positional asphyxia
County: Cook
Narrative: Seven-and-a-half-year-old child was found unresponsive in bed in the morning by his babysitter. The babysitter alerted the parents and the father began CPR while the mother called 911. The child was transported to the hospital where he was pronounced dead. The child had multiple physical and mental disabilities including cerebral palsy, left side paralysis and an inability to speak. It is believed the child reached for a toy, got stuck, and was unable to cry out for help. The child's death certificate noted that his cerebral palsy was a significant condition contributing to his death. Prior History: There was one prior unfounded investigation involving this family. In March 2002, the child's school contacted the hotline to report that the child had come to school with facial injuries to his left eye, cheek, and forehead. The report was unfounded after investigation. Both the mother and babysitter reported that the child had caused the injuries to himself when he became angry at his mother's vacuuming. The child had a history of becoming angry at loud noises. The child was taken to the hospital for evaluation. After learning the child's medical history, the examining doctor opined that the child's injuries could have been self-inflicted. The OIG reviewed records in this case.

Case #60 **DOB May 2002** **DOD April 2003**
Age at death: 10 months
Substance exposed: no
Cause of death: drowning in a bathtub
County: Sangamon
Narrative: Ten-month-old was discovered by his mother's live-in boyfriend face down in the bathtub. The twenty-eight-year-old boyfriend put the ten-month-old and his two-year-old brother in the bathtub and left the bathroom for some undetermined period of time while he picked up the house and did laundry. The twenty-four-year-old mother left the children in the care of her boyfriend to go sell her blood plasma. She asked him to give the children a bath. The mother and boyfriend had been together approximately two months and had been living together for one-and-one-half months. The boyfriend was very upset over the child's death and accepted responsibility for it. The mother and boyfriend were indicated for death by neglect and substantial risk of physical injury to the children. The mother's two surviving children were taken into custody. They were placed with their father in June 2003 and continue to receive services from DCFS. Prior History: There was one prior investigation on this family in January 2003. The father contacted the hotline to report that his three-year-old daughter was burned with a cigarette on her right cheek by her mother's boyfriend (a different boyfriend than the one involved in the child's death). The investigation was unfounded after it was determined that her mother's girlfriend accidentally burned the child. The mother's girlfriend admitted to accidentally burning the child and the father admitted that his daughter told him she ran into the girlfriend's cigarette. The mother and father were going through a divorce and the father wanted the investigator's help in getting back together with the mother. The OIG reviewed this investigation and found it to be appropriately unfounded.

Case #61 **DOB March 2003** **DOD April 2003**
Age at death: 1 month
Substance exposed: no
Cause of death: overlay
County: Cook
Narrative: One-month-old infant was found unresponsive in bed with her fifteen-year-old aunt. The infant's seventeen-year-old mother had asked her sister to put the infant in her bassinet. Instead, the sister put the baby in bed with her and fell asleep. The sister was reported by family members to be a heavy sleeper. The mother discovered that her sister had rolled over on top of the baby. The baby was unresponsive and mother called an ambulance. The baby was transported to the hospital where she was pronounced dead. Prior History: Both the mother and her sister were wards of the Department from June 1998 to June 1999. Their family came to the attention of DCFS in October 1996 when the mother was indicated for medical neglect of another sister. Two indicated reports of physical abuse followed. At the time of the infant's death, the sisters were staying with their grandparents. The infant's nineteen-year-old father is a ward of DCFS. He was reportedly living in the home at the time of the infant's death. He has been a ward of DCFS since May 1985. He is in an independent living program. The OIG reviewed records in this case.

Case #62 **DOB January 1996** **DOD June 2003**
Age at death: 7 years
Substance exposed: no
Cause of death: craniothoracic and abdominal blunt trauma
County: St. Clair
Narrative: Seven-year-old child was riding his bicycle in front of his grandmother's house and began trailing alongside a dump truck. The truck reversed to make a wide turn onto another street, and ran over the child. The child was transported to the hospital where he was pronounced dead. The truck driver was not ticketed because it was determined to have been an accident. Prior History: This family came to the attention of the Department in November 2000 when the mother was indicated for inadequate supervision

and shelter. An intact family case was opened in January 2001. Two more indicated reports followed in March and April 2001, the first for inadequate supervision and shelter and the second for sexual penetration of the six-year-old daughter by a friend of the mother. In January 2002 the children entered foster care on a dependency petition because the mother had been arrested for retail theft. The deceased remained in foster care for nine months. He went through seven placements during that time because of his sexually acting out behavior. He was returned to his mother's care in October 2002. His two sisters remain in foster care in the same relative foster home. They have a goal of return home. The OIG reviewed records in this case.

Case #63 **DOB May 2003** **DOD June 2003**
Age at death: 3 weeks
Substance exposed: no
Cause of death: overlay
County: Cook
Narrative: Three-week-old infant was found unresponsive in the morning by her twenty-seven-year-old mother and forty-four-year-old father. The parents had slept in their bed with the infant and her twin. The parents called the ambulance and the child was transported to the hospital where she was pronounced dead. Prior History: This family came to the attention of the Department in May 2002 when a hotline report was made alleging that the mother attacked the father while he was holding their one-year-old child and that the child suffered an abrasion on her face. Both parents described fighting with each other and the report was indicated against both parents for substantial risk of physical injury to the one-year-old. The parents had five children ranging in age from one to nine. An intact family case was open from June 2002 to October 2002. The OIG reviewed records in this case.

Case #64 **DOB March 1991** **DOD June 2003**
Age at death: 12 years
Substance exposed: no, however, mother has history of alcohol abuse
Cause of death: drowning
County: Winnebago
Narrative: Twelve-year-old foster child drowned in a swimming pool where he went swimming with his biological and foster siblings. The family was visiting the foster mother's adult daughter who followed the children to the pool. The foster mother stayed at the home to make sandwiches to bring to the pool. The child entered the deep end of the pool before the caretaker could stop him. There was no lifeguard on duty. There were two attendants at the pool who reportedly tried to assist the child, but were unsuccessful. Prior History: The child's family has a history with DCFS dating to 1994. The fifty-year-old mother has a history of alcohol abuse. All of her children were in foster care from January 1995 to March 1998. In 2001, the mother left two of her children with relatives and failed to return for them. The youngest child went to live with his father and the other went into foster care. The mother's remaining three children entered foster care in May 2003 when she failed to pick them up from school. The surviving children remain in foster care and have goals of return home. The OIG reviewed records in this case.

Case #65 **DOB February 2002** **DOD June 2003**
Age at death: 16 months
Substance exposed: no
Cause of death: Hanging with a blind cord
County: Cook
Narrative: Sixteen-month-old was discovered hanging from a mini blind cord by her mother. The toddler was strangled by the cord that was woven through the blinds and held them together (not by the cord used to open and close them). The toddler had been taking a nap. The paramedics were called and the child was transported to the hospital where she was pronounced dead. Prior History: This family came to the

attention of DCFS in December 2002 when the hotline was contacted by an assistant principal who reported that the twelve-year-old sibling of the deceased came to school with a large bruise to the left side of his face. The mother admitted to hitting the child on his face with her open hand because she caught him lying. The school noted this was the first incident they were aware of and confirmed that the child had behavioral problems for which he was seeing the school social worker. After a thorough investigation, the mother was indicated for cuts, bruises, and welts and the family was referred to a community based program for counseling. The OIG reviewed records in this case.

Deaths in Which the Manner of Death Was Ruled Natural by the Medical Examiner or Coroner's Office or the Treating Hospital

Case #66 **DOB July 2002** **DOD July 2002**
Age at death: 0
Substance exposed: no
Cause of death: prematurity
County: Cook
Narrative: Fourteen-year-old ward gave birth to a stillborn baby at 21 weeks gestation. Prior History: The teenager has been a ward of the Department since 1990. Parental rights were terminated in 1997. The ward has had numerous placements and has a history of running from them. She has been arrested seven times, most recently in October 2003 when she was charged with possession of a controlled substance. The ward is currently on run. The OIG reviewed records in this case.

Case #67 **DOB December 2001** **DOD July 2002**
Age at death: 6 months
Substance exposed: yes, cocaine, opiates
Cause of death: congenital heart disease
County: Cook
Narrative: Six-month-old baby was taken to the hospital following difficulty breathing. Attempts to resuscitate the baby failed. The baby, who had a history of bronchitis, had been taken to the hospital earlier by the foster parent. Doctors prescribed antibiotics and sent the child home. Later, the foster parent checked on the baby and found that she was not breathing. Prior History: This family has a history with DCFS dating to March 1997 when the then thirty-year-old mother was investigated for inadequate food for her three teenage sons. The mother was indicated, but a case was not opened as the three boys went to live with their maternal grandmother through an informal arrangement. Since that time, the mother gave birth to two substance-exposed infants, one of whom was the deceased. Both children entered foster care and were placed with their maternal aunt. She obtained subsidized guardianship of the surviving child in November 2001. The three oldest children continue to live with their grandmother. The OIG conducted a preliminary review in this case.

Case #68 **DOB February 1997** **DOD July 2002**
Age at death: 5 years
Substance exposed: no
Cause of death: sepsis and infection due to complications of a bone marrow transplant
County: White
Narrative: Five-year-old child died in the hospital after a bone marrow transplant to treat her cancer. The child was diagnosed with cancer in August 2001. Prior History: The thirty-one-year-old father, who is hearing impaired and uses sign language, had a pending investigation against him at the time of the child's death. He also had a previously unfounded report on his step-children. The father was the primary caretaker for the child as he and the mother were separated and the mother had little contact with him. In April 2002, the home health agency reported that the father was not feeding the child nutritious

meals that she needed because of her illness. While the investigation was pending, the hospital contacted the hotline to report that the child had not shown up for an appointment for a CAT scan. Medical staff further reported that visiting nurses would go to the home to give the child shots for her nausea and there were times the family was not at home. The Department arranged for services to the family while the investigation was pending. After the child went into the hospital for her bone marrow transplant, the father left to drive his girlfriend to Texas. The child's condition deteriorated while her father was gone and the hospital maintained her on life support until her father could get back to see her. The father was indicated for medical neglect of the child. The OIG reviewed records in this case.

Case #69 **DOB April 1987** **DOD July 2002**
Age at death: 15 years
Substance exposed: unknown, mother has a history of substance abuse
Cause of death: multi-system organ failure
County: Cook
Narrative: Fifteen-year-old medically complex ward died in the hospital after a two-week stay for treatment of pneumonia, diabetes, and dehydration. Prior History: The deceased's family has a history with DCFS dating to 1991 when the mother was indicated for inadequate supervision of her five children and medical neglect of the deceased. The mother went on to have three more children, two of whom were born substance-exposed. The ward had lived at a residential care facility since February 1992. Six of the ward's siblings were returned to their mother's care in 1998. The seventh, a medically complex child, was adopted in 1996. The OIG conducted a preliminary review of this case.

Case #70 **DOB January 2002** **DOD August 2002**
Age at death: 6 months
Substance exposed: no, however, the mother has a history of substance abuse
Cause of death: liver failure with mesenteric ischemia, due to liver transplant, biliary atresia
County: Cook
Narrative: Death of six-month-old ward who was born with a congenital liver disorder. Prior History: The infant became a ward of DCFS in May 2002 after his twenty-one-year-old mother was indicated for medical neglect of the infant related to his illness. He lived with the same foster parent until his death. A two-year-old sibling was allowed to remain at home with his mother and grandparents under an order of protection. In October 2002, the mother was indicated for inadequate supervision of the two-year-old. In November 2002, the court found that the mother violated the order of protection and ordered temporary custody of the two-year-old. Despite concerns of the worker about criminal histories of the mother, grandmother, and grandfather; domestic violence in the home; the grandmother's mental illness; the mother's drug use and mother's failure to cooperate with her caseworker and engage in services, in December 2002, the juvenile court judge found that the two-year-old wasn't abused or neglected and he was returned home. The family's case with DCFS was closed. The OIG reviewed records in this case.

Case #71 **DOB April 2002** **DOD August 2002**
Age at death: 3 months
Substance exposed: yes
Cause of death: multiple organ failure due to enterococcal septic shock due to short-gut syndrome
County: Cook
Narrative: Three-month-old died in the hospital where he had been since birth. The infant was born substance exposed with syphilis and weighed only four pounds. Prior History: The infant was his thirty-three-year-old mother's seventh substance-exposed infant. The mother has a substance abuse history dating to 1988. All ten of her children have been DCFS-involved. Four are currently in DCFS custody

and five have been adopted. The OIG reviewed the DCP investigation of the infant's substance-exposed birth.

Case # 72 **DOB November 2001** **DOD August 2002**
Age at death: 9 months
Substance exposed: yes, cocaine
Cause of death: hypoxic ischemic encephalopathy due to microcephaly due to profound development impairment
County: Cook
Narrative: Nine-month-old medically complex ward died at his residential care facility. The ward was born prematurely and substance-exposed with multiple medical problems. He spent the first two months of his life in the hospital and was placed in the residential care facility following his release. The DCFS guardian executed a Do Not Resuscitate order for the child in August 2002 after she met with the mother and consulting doctors. Prior History: The twenty-five-year-old mother of the deceased has a history with DCFS dating to 1996 when she gave birth to her first substance-exposed infant. She went on to have three more children, all born substance-exposed. The three surviving children are in the private guardianship of relatives. The OIG reviewed records in this case.

Case #73 **DOB December 2001** **DOD August 2002**
Age at death: 7-½ months
Substance exposed: no
Cause of death: congenital anaplastic astrocytoma
County: Madison
Narrative: Seven-and-a-half-month-old infant died from brain cancer. She was receiving hospice care in her home. Prior History: The mother of the deceased was a ward from January 1994 to January 1999. In July 2002, the hotline received a report alleging that the twenty-one-year-old mother burned her three-year-old son and put her infant daughter at substantial risk of physical injury. A second report of medical neglect of her daughter was received three days later. Both reports were unfounded after investigation. The mother and three-year-old said that he burned his head on a lamp that did not have a shade on it. The burn was barely discernible and the child's pediatrician did not suspect any abuse or neglect. Further, the report was made by a collateral source who had a strained relationship with the mother over child care issues. The medical neglect report was also unfounded as hospice nursing staff and the infant's pediatrician said the mother was ensuring that the infant's needs were met. The OIG reviewed records in this case.

Case #74 **DOB October 1983** **DOD August 2002**
Age at death: 18 years
Substance exposed: unknown
Cause of death: brain tumor
County: Cook
Narrative: Eighteen-year-old ward died in the hospital from a brain tumor. She had been hospitalized for several weeks prior to her death. The ward was diagnosed with recurring brain tumors in 1992. She underwent approximately six tumor removal surgeries and one course of chemotherapy. Toward the end of her illness, surgery was no longer an option and the ward declined chemotherapy. Prior History: The deceased became a ward, along with her brother and sister, in October 1986 because of neglect. The ward had numerous foster and residential placements prior to entering an independent living program in February 2002. In June 2002, the ward gave birth to a daughter. Her older sister is now caring for the child. The OIG conducted a preliminary review of this case.

Case #75 **DOB March 1992** **DOD August 2002**
Age at death: 10 years
Substance exposed: No
Cause of death: bronchial asthma
Narrative: Ten-year-old child with a history of asthma experienced shortness of breath in the morning and was taken to the hospital by ambulance. He died in the emergency room. Prior History: There were four hotline reports involving this family between July 1999 and December 2001. One report was indicated. In July 1999 the twenty-three-year-old mother's thirty-three-year-old boyfriend was indicated for sexual molestation of the mother's eight and nine-year-old daughters. The boyfriend was incarcerated and a case was not opened. Two more investigations of sexual abuse to the children were unfounded in March 2001 and March 2002. In April 2001 a hotline report for medical neglect of the child's asthma was unfounded. However, a review of the child's medical records by the OIG revealed several known risk factors associated with increased asthma fatality (unknown asthma severity; frequent ER visits and hospitalizations for asthma attacks; use of a relief inhaler only; and lack of a long-term controller medication, peak flow meter, and asthma action plan). The OIG reviewed records in this case. A previous OIG investigation of the deaths of five DCFS wards from asthma led to the promulgation of DCFS Policy Guide 2002.01 (January 2002) Case Management Guidelines for Children's Asthma Management and asthma education training for workers.

Case #76 **DOB July 2002** **DOD August 2002**
Age at death: 1-½ months
Substance exposed: yes, alcohol
Cause of death: congenital heart disease
County: Will
Narrative: One-and-a-half-month-old baby was found unresponsive by her twenty-year-old mother when the mother went to check on the baby in the morning. The mother took the baby to the hospital where she was pronounced dead. The mother told medical staff that the baby had a low-grade fever the previous night, and she gave her some medicine to bring the fever down. Medical staff noted that it appeared as though the mother had been drinking as she displayed slurred speech and smelled of alcohol. Prior History: The family came to the attention of DCFS in January 2001 when the mother left her two-and-a-half-year-old and six-month-old children home alone while she went to Chicago to visit the children's father. The Department placed the children with the maternal grandmother, and the children have remained there since. In July 2001, the mother gave birth to her third child. A month later, the mother and father were indicated for inadequate supervision after a family member found the parents too intoxicated to care for the baby. The baby entered foster care in September 2001. The mother continued to drink. Shortly before the birth of the deceased the mother entered a drug rehabilitation program, however, she prematurely left the program days before giving birth. Nevertheless, the agency servicing the case allowed the mother to keep the baby in her care. The three surviving children remain in foster care. The grandmother is planning to adopt the two oldest siblings and the youngest child is in a pre-adoptive placement. The OIG is conducting a full investigation of this child's death. A report to the Director is expected.

Case #77 **DOB March 2002** **DOD August 2002**
Age at death: 5 months
Substance exposed: yes, cocaine
Cause of death: prematurity
County: Cook
Narrative: Five-month-old infant found unresponsive by her siblings, ages 8, 6 and 4. They notified their twenty-seven-year-old mother who contacted 911. The infant was transported to the hospital where she was pronounced dead. The infant was born prematurely at 24 weeks gestation weighing a little over one pound. She tested positive for cocaine at birth. She remained in the hospital for three months following

her birth. Prior History: This family first came to the attention of the Department in July 1997 when the hotline was contacted with an allegation of medical neglect to one of the children who was sick and had not been taken to the doctor. The report was indicated and an intact family case was open from July 1997 to December 1997. Another allegation of medical neglect in December 2001 was unfounded. In March 2002 the hotline was contacted when mother gave birth to the deceased who was born substance-exposed. The mother was indicated for substance misuse and an intact family case was opened. The mother participated in substance abuse treatment and was reported to be doing well. The case was closed in December 2002. The OIG reviewed records in this case.

Case #78 DOB March 1998 DOD September 2002
Age at death: 4-1/2 years
Substance exposed: no
Cause of death: cardiopulmonary failure due to pneumonia due to cystic fibrosis
County: Cook
Narrative: Four-and-a-half-year-old died in the hospital where she had been staying since going into crisis from her cystic fibrosis. Prior History: There were two prior investigations involving the care of the deceased. In March 2002 a DCP investigation was unfounded for failure to thrive. A second report, made 9/3/02, was pending at the time of the child's death. The hospital contacted the hotline alleging medical neglect, reporting that the child entered the hospital in very poor condition and the twenty-four-year-old mother should have noticed the warning signs before the child deteriorated to such an extent. The investigation was unfounded after the child died. A DCFS nurse determined that the mother had not received adequate training on how to recognize warning signs that her daughter was suffering from respiratory distress. The OIG reviewed the DCP investigation.

Case #79 DOB June 2002 DOD September 2002
Age at death: 3 months
Substance exposed: no
Cause of death: Sudden Infant Death Syndrome (SIDS)
County: Alexander
Narrative: Three-month-old infant was found unresponsive and blue with blood coming from his mouth by his thirty-two-year-old mother. 911 was called and paramedics arrived and determined the infant was already dead. The coroner was summoned and the infant was pronounced dead. The infant was born prematurely at thirty weeks gestation weighing only 2-1/2 pounds. He spent the first five weeks of his life in the hospital. Prior History: Approximately one month earlier, the hotline was contacted after the infant was seen in the emergency room and diagnosed with a mid-shaft fracture of his left femur. A DCP investigation revealed that the infant's thirteen-year-old and eight-year-old sisters were fighting over who would hold the baby during a visit to their mother's home (they lived primarily with their father) and that the eight-year-old pulled on the infant's leg. Doctors treating the infant believed the explanation was consistent with the injury. The case was indicated for inadequate supervision and an intact family case was opened. The case was closed in January 2003. The OIG reviewed records in this case.

Case #80 DOB June 2002 DOD September 2002
Age at death: 3 months
Substance exposed: no, however, mother has a history of substance abuse
Cause of death: cardiopulmonary arrest of undetermined cause following a prodrome of lethargy, emesis and shortness of breath
County: St. Louis, Missouri (death)
Clay County (residence)
Narrative: Three-month-old baby was brought to the hospital by his thirty-one-year-old mother after he had been vomiting and exhibiting trouble breathing. The baby died in the hospital the next day. Prior History: This family has a history with DCFS dating to May 1993 when the police reported substantial

risk of physical injury to a one-year-old in the home because of alcohol abuse and domestic violence of the parents. In April 1995 two children, ages 9 months and 3 years, entered foster care after the father became violent while intoxicated. A third child born in October 1996 was allowed to remain at home with her parents until May 2000 when the parents were indicated for inadequate shelter. The child was returned home in February 2001 and guardianship was returned to the mother, who separated from the father, in April 2002. The two older children have been adopted. The OIG reviewed records in this case.

Case #81 **DOB April 1999** **DOD September 2002**
Age at death: 3 years
Substance exposed: no
Cause of death: end stage liver disease
County: Cook
Narrative: Three-year-old ward with AIDS died in her sleep. She was suffering from kidney and liver failure and a do not resuscitate order was put in place eleven days prior to her death. The child died in her sleep at the residential facility for medically complex children where she had resided since November 1999. Prior History: The child first entered the residential facility as a voluntary placement. In April 2000 the child's nineteen-year-old mother was indicated for medical neglect of the child for failing to learn how to care for her following a hospitalization. The child became a ward of DCFS in May 2000. Her mother visited her regularly at her placement. This case was reviewed as part of a larger investigation on pediatric palliative/hospice care. A report entitled Pediatric Palliative/Hospice Care for Terminally Ill Children in State Care, OIG #020,987, was sent to the Director on February 21, 2003.

Case #82 **DOB August 2002** **DOD September 2002**
Age at death: 1 month
Substance exposed: yes, cocaine
Cause of death: sepsis due to prematurity due to mother's poly-drug abuse
County: Cook
Narrative: One-month-old infant died in the hospital where she had been treated since her premature, substance-exposed birth. The infant required surgery for an obstruction to her gastrointestinal tract and developed an infection that resulted in sepsis. Prior History: The thirty-seven-year-old mother of the deceased has a history with DCFS dating to May 1990 when she gave birth to a substance-exposed infant. In April 1991 the mother's three children entered foster care and were placed with their maternal grandmother. They were adopted by her in November 1999. She has no other children in her custody. The OIG reviewed records in this case.

Case #83 **DOB November 2000** **DOD September 2002**
Age at death: 1-½ years
Substance exposed: yes, cocaine
Cause of death: respiratory distress due to prematurity
County: Cook
Narrative: One-and-a-half-year-old medically complex ward experienced respiratory distress in his nursing facility and was taken by ambulance to the hospital where he was pronounced dead fifteen minutes later. Prior History: The ward entered foster care following his birth and lived in the hospital and a residential care facility his entire life. His thirty-six-year-old mother has a history of mental illness and substance abuse. She was a ward of the state from 1976 to 1985. She became involved with DCFS as a parent in October 1992 when she was indicated for inadequate supervision of her oldest daughter. The mother has had five children, two of whom were born substance-exposed (the mother tested positive for cocaine at the birth of a third, but the baby tested negative). Two of the surviving siblings have been adopted and the other two are placed together in foster care. They have permanency goals of adoption. The OIG conducted a preliminary review of this case.

Case #84 **DOB September 2002** **DOD September 2002**
Case #85 **DOB September 2002** **DOD September 2002**
Age at death: 0
Substance exposed: no
Cause of death: prematurity
County: Cook
Narrative: Eighteen-year-old ward was transported to the hospital by ambulance after she began experiencing labor pains and bleeding. An emergency caesarian section was performed. Twin girls were born at five months gestation. They died shortly after birth. Prior History: The ward was the youngest of four siblings whose forty-nine-year-old mother has a long history with the Department dating to September 1983. The mother's two oldest children entered foster care in February 1985 and the ward and another sibling entered foster care in August 1993. The ward went through several foster placements, the longest lasting two years. In July 1998 she was placed in a group home and eventually transitioned to independent living where she remains. The ward had been receiving prenatal care. The OIG conducted a preliminary review of this case.

Case #86 **DOB April 2002** **DOD October 2002**
Age at death: 5 months
Substance exposed: no
Cause of death: respiratory failure due to tracheal stenosis; pulmonary atelectasis
County: DuPage
Narrative: Five-month-old infant died in the hospital. He was born with a congenital heart defect and spent all but three days of his life in the hospital. Prior History: David was the product of incest. His eighteen-year-old mother, who emigrated from Mexico a year prior and spoke only Spanish, was raped by her twenty-eight-year-old cousin. In July 2002 when the infant was being discharged, the hospital contacted DCFS requesting services for the mother because of her lack of resources and support and the complex medical problems of her child. Three days after the infant's discharge, the mother contacted the hospital stating that the infant had diarrhea and puffy eyes. She was instructed to bring the child to the emergency room, but did not do so until the following day when the child had to be admitted to the pediatric intensive care unit. The hotline was contacted, but a report of medical neglect was unfounded as mother did not have transportation to the hospital and hospital staff felt she was not neglectful, but lacking in education and support. DCFS provided services to the mother, including funds to purchase baby equipment in anticipation of the infant's return home from the hospital. Following the infant's death, DCFS referred the mother for grief counseling. Her case was closed in November 2002. The OIG reviewed records in this case.

Case #87 **DOB January 2002** **DOD October 2002**
Age at death: 8 months
Substance exposed: no
Cause of death: complex congenital heart disease
County: Cook
Narrative: Eight-month-old infant died in the hospital from a heart condition. The infant had been hospitalized since birth. Prior History: This family first came to the attention of the Department in January 2002 after the infant's birth. A case was opened to provide preventive services to the twenty-one-year-old mother, her four-year-old daughter, and the ill infant. The case was closed in December 2002. The OIG conducted a preliminary review of this case.

Case #88 **DOB August 2002** **DOD October 2002**
Age at death: 2 months
Substance exposed: yes, cocaine
Cause of death: Sudden Infant Death Syndrome (SIDS)

County: Winnebago
Narrative: Two-month-old baby was found unresponsive by his foster mother who called 911 and began CPR. The baby was later pronounced dead by the coroner. Prior History: The baby entered foster care three days after his birth. He and his twenty-seven-year-old mother tested positive for cocaine at the time of his birth. The mother admitted to using drugs since 1995. Her landlord said she was prostituting for drug money. The mother said the father of the baby was a man who raped her, but who was never prosecuted. The mother was discharged from the hospital before the baby and could not be found by the child protection investigator. The man the mother reported to be the father came forward to obtain custody of the baby. He disputed that he raped the mother and said they had dated for three months. Paternity testing was in progress when the baby died. The deceased had one half-sibling who resides with her father, the mother's estranged husband. The OIG reviewed records in this case.

Case #89 **DOB October 2002** **DOD October 2002**
Age at death: 26 days
Substance exposed: no
Cause of death: Late onset neonatal sepsis due to infection with beta Steptococcus group B
County: Macon
Narrative: Twenty-six-day-old infant was found unresponsive by his fifteen-year-old mother. She took him to the hospital where he was pronounced dead. The infection the infant died from was likely contracted during labor and delivery, but did not manifest itself until later. Prior History: The mother has been a ward of DCFS since February 1990 because of her mother's neglect. She has one other child, a two-year-old daughter. The ward has had numerous placements. At the time of her baby's death, the mother and her two children were living in a foster home where the ward had been placed in July 2002. The OIG reviewed records in this case.

Case #90 **DOB June 1996** **DOD October 2002**
Age at death: 6 years
Substance exposed: no, however, mother has a history of marijuana abuse
Cause of death: trisomy 13
County: Cook
Narrative: Six-year-old medically complex child died. According to his doctor, he lived longer than the normal life expectancy for a child in his condition. Prior History: This family came to the attention of DCFS in January 2001 when a report was made alleging the twenty-five-year-old mother was beating her children and feeding them marijuana. The report was unfounded on those allegations, but indicated for substantial risk of physical injury to the deceased. A preventive services case was opened and closed in May 2002. In October 2002 a report of medical neglect of the deceased was unfounded. The school where the child was supposed to attend contacted the hotline to report that the child had not shown up for the new school year and that he was supposed to receive numerous medical services through the school. The DCP investigation revealed that the child had been hospitalized during the month of September and had not yet been cleared by his doctor to attend school. The child and his two siblings appeared well-cared for by their mother and grandmother with whom they lived. The OIG reviewed the DCP investigation.

Case #91 **DOB October 2002** **DOD October 2002**
Age at death: 13 days
Substance exposed: no
Cause of death: bronchopneumonia
County: Cook
Narrative: Thirteen-day-old infant was found unresponsive by her twenty-one-year-old father in the morning. He woke the eighteen-year-old mother who called 911. The infant was transported to the

hospital where she was pronounced dead. Prior History: The mother has been a ward of DCFS since April 1994 because of her mother's substance abuse and neglect. She has one other child, a three-year-old daughter. The ward and her two children were living with the ward's grandmother who is her foster parent. The children's father was also staying in the home to help care for the newborn. The ward had been placed with her grandmother since entering foster care. She was a participant in the teen parenting network. The OIG reviewed records in this case.

Case #92 **DOB October 2002** **DOD November 2002**
Age at death: 16 days
Substance exposed: no
Cause of death: herpes simplex virus and severe pulmonary consolidation
County: St. Louis, Missouri (death)
Sangamon (residence)
Narrative: Sixteen-day-old baby died in the hospital where she was being treated for herpes simplex virus contracted during labor and delivery. The child had been discharged following birth as a healthy infant, but was brought back to the hospital four days later. She was transferred to a hospital in St. Louis, Missouri where she later died. Symptoms for the virus usually do not appear for several days after birth. Prior History: This family became involved with the Department in July 2001 when a report was made alleging inadequate supervision of a three-year-old and five-month-old by their nineteen-year-old mother. The report was indicated and DCFS opened an intact family case. Later in the year the mother assigned guardianship of her children to relatives and her case was closed in January 2002. The OIG reviewed records in this case.

Case #93 **DOB December 2001** **DOD November 2002**
Age at death: 11 months
Substance exposed: no
Cause of death: fukuyma dystrophy
County: Cook
Narrative: Eleven-month-old infant became unresponsive and was transported to the hospital, where he died. The child had a rare form of muscular dystrophy and his death was not unexpected. Prior History: This family came to the attention of DCFS four months prior to the child's death when a hospital contacted the hotline to ensure that the child got a second opinion about his illness. The hospital had wanted the child to have a confirmatory biopsy for his illness and before undergoing that procedure, the family wanted a second opinion. The Department investigated the allegation and appropriately unfounded it based on the family's scheduled appointment for a second opinion. The OIG reviewed records in this case.

Case #94 **DOB October 2002** **DOD November 2002**
Age at death: 1 month
Substance exposed: no
Cause of death: systemic pulmonary imbalance due to severe congenital heart disease
County: Cook
Narrative: One-month-old ward died following surgery to correct a heart defect with which she was born. Prior History: This family's history with DCFS dates to April 1987 when the mother was indicated for medical neglect of her one-year-old child for refusing to have him immunized. Subsequent reports of abuse/neglect were indicated and the child entered foster care in August 1999. The mother gave birth to a second child in December 2000. This child entered foster care in May 2002 after two hotline reports of abuse/neglect. The deceased entered foster care based on her mother's history and her parents' failure to participate in services. The surviving siblings remain in foster care. The older child has a goal of independence and the younger a goal of return home. The OIG reviewed records in this case.

Case #95 **DOB September 2002** **DOD December 2002**
Age at death: 2 months
Substance exposed: no
Cause of death: complications of a viral syndrome
County: Broward County, Florida (death)
Will (case management)
Narrative: Two-month-old infant was found unresponsive by her maternal grandmother in the morning. The maternal grandfather began CPR and 911 was called. The infant was transported to the hospital where she died the following day. The infant and her family were on vacation in Florida visiting the maternal grandparents. The infant was put to bed in an antique crib with pillows and blankets rolled up in it to create a bumper pad. Prior History: Between August 1999 and December 2000, the mother was indicated on one report of inadequate supervision and two reports of cuts, welts, and bruises. An intact family case was opened in January 2001. There were subsequent incidents and calls to the hotline alleging abuse to the mother's two older children. Following an incident in February 2002, the two older children went to live with their father. A four-year-old daughter remained in the home with her mother and father and the intact family case remained open until June 2003. The OIG reviewed records in this case.

Case #96 **DOB August 2002** **DOD December 2002**
Age at death: 3 months
Substance exposed: no
Cause of death: Sudden Infant Death Syndrome (SIDS)
County: Cook
Narrative: Three-month-old infant was found unresponsive by his nineteen-year-old mother. The infant was transported to the hospital where he was pronounced dead. The mother and infant slept together in the mother's bed. Prior History: The mother had been a ward of the Department since July 1994 when she was eleven years old. She has two surviving children who have been in foster care since November 2001 because of substantial risk of physical injury/environment injurious to health and welfare. Ten days before the baby's death, the mother was indicated for substantial risk of physical injury when she left the baby on his twenty-year-old father's porch as a way of getting the father's attention. The baby was not removed from her care. The mother was in an independent living program and resided in an apartment with her son. The parents had a substantial history of domestic violence between them. They recently signed surrenders, freeing the two surviving children for adoption. The OIG conducted a full investigation of this case. A report was sent to the Director on November 3, 2003.

Case #97 **DOB December 2002** **DOD December 2002**
Age at death: 1 day
Substance exposed: no
Cause of death: extreme prematurity
County: Cook
Narrative: Baby was born by C-section at 24 weeks gestation due to fetal distress following premature rupture of membranes. He died in the hospital the following day. Prior History: The infant's twenty-four-year-old mother has a history with DCFS dating to 1988, when as a child she was a victim of physical and sexual abuse. In December 1996 she gave birth to a daughter. In March 1997 the mother was indicated for neglect of her daughter and she entered foster care. She was adopted in July 1999. In November 1997 the mother gave birth to another daughter and was indicated in November 2000 for substantial risk of physical injury. The child went to live with her father and he obtained legal custody of her in June 2001. In August 2002 an allegation that the child was hit and injured by her mother during a visit was unfounded. The OIG reviewed this investigation.

Case #98 **DOB July 2002** **DOD December 2002**
Age at death: 4 months
Substance exposed: no
Cause of death: Sudden Infant Death Syndrome (SIDS)
Narrative: Seventeen-year-old mother was sleeping at her sister's house on a couch with her four-month-old baby. The mother, a ward of the state, awoke to find the baby cold and unresponsive. Prior History: The mother's family had been involved with the Department since 1988 when an intact family case was opened for neglect. The mother and her three siblings entered foster care in 1990. At the time of the baby's birth and death, the mother was living with a relative. Her case was closed in March 2003 when she turned eighteen. She has two surviving children, ages three and four. The OIG reviewed records in this case.

Case #99 **DOB September 2002** **DOD December 2002**
Age at death: 3 months
Substance exposed: yes, cocaine
Cause of death: Sudden Infant Death Syndrome (SIDS)
County: Cook
Narrative: Three-month-old infant was found face down in his crib by his thirty-three-year-old mother who went to check on him around 2:00 a.m. The mother called for her aunt who is a nurse. The aunt performed CPR while an ambulance was called. The infant was transported to the hospital where he was pronounced dead. Prior History: There was an intact family case open at the time of the infant's death as a result of his being born substance-exposed. Another case had been open earlier from June 1994 to October 1997 when the mother gave birth to her first substance-exposed infant. After the infant was born substance-exposed, the mother agreed to go live with her mother who was caring for her other five children. The worker attempted to get the mother into drug treatment and have the grandmother made protective payee of the family's public aid funds. The case was closed in March 2003. This case was reviewed as part of a larger investigation on infant sleep safety. A report entitled Child Death Investigations Involving Infant Sleep Safety, OIG #032,162, was sent to the Director on June 30, 2003.

Case #100 **DOB December 2002** **DOD December 2002**
Age at death: 17 days old
Substance exposed: no
Cause of death: malignant cerebral edema due to probable vascular malformation
County: Winnebago
Narrative: Seventeen-day-old infant turned blue and stopped breathing. He was transported to the hospital by ambulance and died the following day. Abuse was initially suspected as the child had bruising on his left ear, but an autopsy revealed the child died from a condition similar to an aneurysm. The child lived at home with his nineteen-year-old mother and nineteen-year-old father. Prior History: The infant's mother had one prior indicated report. In March 2002, the hotline was contacted with an allegation of inadequate supervision. The mother was asked by a friend with whom she was living to watch the friend's two children, ages 7 and 9, when they returned home from school. The mother agreed, but left the children home alone once they got home from school. The children called their father who contacted the police to ensure the children's safety. The mother was indicated for inadequate supervision. The OIG reviewed records in this case.

Case #101 **DOB October 2002** **DOD December 2002**
Age at death: 2 months
Substance exposed: yes, cocaine
Cause of death: Sudden Infant Death Syndrome (SIDS)
County: Cook

Narrative: Two-month-old infant was found unresponsive by his foster mother. 911 was called and the infant was transported to the hospital where he was pronounced dead. The foster mother had placed the child to sleep face down in a bassinet. Prior History: This family has a history with DCFS dating to December 1995 when the mother gave birth to her first substance-exposed infant. The deceased was his thirty-eight-year-old mother's fourth child. All four children were born substance-exposed, and all were placed in foster care. One child has been adopted, the second is in subsidized guardianship, and the third is in a home of relative foster placement. The OIG reviewed records in this case.

Case #102 **DOB December 2002** **DOD December 2002**
Age at birth: 0
Substance exposed: yes
Cause of death: abruptio placenta due to cocaine abuse by mother
County: Madison
Narrative: Baby was stillborn at the hospital. The thirty-seven-year-old mother of three (a nine-year-old daughter in the home, a son residing with his father's family out of state, and an adult daughter) presented at the hospital with an abruptio placenta (prematurely detached placenta). A c-section was performed to deliver the baby, but she was stillborn. Both the mother and baby tested positive for cocaine. Prior History: This family came to the attention of DCFS in July 1999. The mother was indicated for inadequate housing and an intact family case was opened. In October 1999 the mother was indicated for inadequate supervision. The mother has a history of substance abuse and depression. For the life of the intact family case the mother failed to maintain stable housing and comply with substance abuse and psychological treatment. A relative assumed guardianship of the nine-year-old daughter and the case was closed. The OIG reviewed records in this case.

Case #103 **DOB June 2002** **DOD December 2002**
Age at death: 6 months
Substance exposed: no
Cause of death: dehydration due to gastroenteritis
County: Cook
Narrative: Twenty-two-year-old biological mother was feeding six-month-old infant when infant began to have trouble breathing. Mother called the fire department and paramedics responded. The child was transported to the hospital via ambulance and pronounced dead on arrival. The child had been ill with a fever and diarrhea and the mother had given the infant acetaminophen as prescribed by her pediatrician. The medical examiner did not find that any neglect contributed to the infant's death. Prior History: This family came to the attention of the Department in June 2002 when the twenty-two-year-old biological father of the deceased child was indicated for cuts, bruises, welts, abrasions and oral injuries against his thirteen-year-old, disabled sister. In November 2002 the biological father was indicated a second time for cuts, bruises, welts, abrasions and oral injuries against his sister. The mother requested that her son leave her home and an intact family case was open from January 2003 to July 2003. The OIG reviewed records in this case.

Case #104 **DOB May 2000** **DOD January 2003**
Age at death: 2-1/2 years
Substance exposed: no
Cause of death: occlusion of tracheostomy tube status post laser oblation of granulation tissue due to subglottic stenosis
County: Cook
Narrative: Two-and-a-half-year-old medically complex child was found unresponsive by his twenty-two-year-old father in the morning. 911 was called and the child was transported to the hospital where he was pronounced dead. A DCP investigation of the child's death was unfounded. The child received regular nursing care and appeared well-cared for by his parents. There is one surviving child, a four-year-old

daughter. Prior History: This family's first contact with DCFS was in February 2002 when a preventive services case was opened. The family was provided with Norman funds and home visits were made. The worker observed no concerns and the visiting nurses reported the family was doing well. The case was closed in September 2002. While the case was still open, in September 2002, a hotline report was made alleging inadequate food in the home. The DCP investigator visited the home, found food in the home, and spoke with visiting nurses who reported there was always food in the home. The investigation was unfounded. The OIG reviewed records in this case.

Case #105 **DOB January 2003** **DOD January 2003**
Age at death: 19 days
Substance exposed: no
Cause of death: Sudden Infant Death Syndrome (SIDS)
County: Winnebago
Narrative: Nineteen-day-old infant was in bed with his twenty-nine-year-old father and one-year-old sibling taking a nap when the father noticed the baby was not breathing. The father attempted CPR and the infant was taken to the hospital where he was pronounced dead. Prior History: The family had an open case at the time of the baby's death as their fourteen-year-old adopted daughter was in placement. The parents had become foster parents in 1997, and the fourteen-year-old child was placed in their home shortly thereafter. The parents adopted the teen in September 1998. The father was subsequently indicated on three reports of abuse to the teenager in February 1999 (substantial risk of sexual injury), April 2001 (cuts, welts, and bruises), and July 2001 (cuts, welts, and bruises). After the July incident, the parents hospitalized the teenager at a mental health center where she remained for three months. When she was ready for discharge, the parents refused to pick her up and they were indicated on a report of abandonment. The teenager is placed in a group home. The parents have refused all services for reunification. A February 2002 report of medical and environmental neglect to a daughter born in December 2001 was unfounded. Following the infant's death, protective custody was taken of the one-year-old sibling. A DCP investigation was conducted and the parents were indicated for substantial risk of sexual abuse to their one-year-old daughter based on the February 1999 indicated report. In May 2003 the child was placed with her mother. The Department retains guardianship of the child and the family continues to receive services. The OIG reviewed records in this case.

Case #106 **DOB July 1990** **DOD February 2003**
Age at death: 12 years
Substance exposed: no
Cause of death: cystic fibrosis
County: St. Clair
Narrative: Twelve-year-old child died in the hospital where she had been treated for several weeks for cystic fibrosis. Prior History: This family has a history with DCFS dating to September 1991 when the mother was indicated for failure to thrive of the child. The child entered foster care where she remained until October 1992 when she was placed with her mother. The child remained in the guardianship of DCFS until July 1994. The mother's four other children remained in her custody. In October 2001 the hotline received a report of medical neglect to the deceased. This report was indicated in January 2002 against the thirty-six-year-old mother and thirty-five-year-old father for medical neglect of the deceased and inadequate shelter of the other children. The deceased's paternal grandmother assumed custody and guardianship of the deceased and an intact family case was open until July 2002. The OIG conducted a preliminary review of this case.

Case #107 **DOB February 2003** **DOD February 2003**
Age at death: 0
Substance exposed: yes
Cause of death: extreme prematurity

County: Winnebago
Narrative: Premature infant was born at 5 months gestation weighing approximately one pound. She died the same day. The infant's death certificate notes that maternal use of cocaine was a significant condition contributing to her death. The mother was indicated for death by neglect. She admitted to smoking crack cocaine the night before she gave birth. Prior History: This family has a history with DCFS dating to November 1999 when the mother gave birth to her first child who was born substance-exposed. The child entered foster care in February 2000. The mother gave birth to a second child in July 2001. She admitted to using drugs throughout this pregnancy. This child entered foster care at birth. Both children have been adopted. The OIG conducted a preliminary review of this case.

Case #108 **DOB February 1986** **DOD February 2003**
Age at death: 17 years
Substance exposed: unknown, mother has a history of substance abuse
Cause of death: Alveolar Rhabdomyosacroma
County: Cook
Narrative: Seventeen-year-old ward died in the hospital from cancer seven days after his birthday. The rapid-spreading cancer, in which malignant tumors are derived from skeletal muscles, was diagnosed only a month earlier. Prior History: This family came to the attention of DCFS in September 1991 when police found the deceased and his four siblings home alone. They entered foster care in October 1991. Two more children entered foster care following their substance-exposed births. They were released to their father's custody. Parental rights to the five children in custody were terminated in July 1998. Two of the children have been adopted, one is in independent living, and the fourth surviving child is in a specialized foster home and a participant in the teen parenting network. The deceased lived in his foster home since July 1997. He had a permanency goal of independence. The OIG conducted a preliminary review of this case.

Case #109 **DOB January 1998** **DOD March 2003**
Age at death: 5 years
Substance exposed: yes, cocaine
Cause of death: seizure disorder
County: Cook
Narrative: Five-year-old medically complex child was found unresponsive in the morning. Among her diagnoses were hydrocephalus, seizure disorder, and hip dysplasia. She took regular medication for her seizure disorder. Prior History: This child was born substance-exposed in January 1998 and her twenty-three-year-old mother was indicated for substance misuse. An intact family case was opened. The child entered foster care in March 1998 after her mother was indicated for failure to thrive and medical neglect of the child. Parental rights to the child were terminated in October 2002. She was in the process of being adopted by her foster parents with whom she had lived since June 1999.
The OIG conducted a preliminary review of this case.

Case #110 **DOB February 2003** **DOD March 2003**
Age at death: 1 month
Substance exposed: yes, cocaine
Cause of death: respiratory failure due to multiple medical problems
County: Cook
Narrative: One-month-old infant died in the hospital where he had been since his birth. The infant was born with severe neurological and other medical problems following a breech birth. The mother tested positive for cocaine at the time of the infant's birth. The baby could not be tested because of his medical problems. Prior History: This family has a history with DCFS dating to 1991 when the now thirty-eight-year-old mother gave birth to her first substance-exposed infant. The mother gave birth to five children. She used drugs during her last three pregnancies. The four surviving children have all spent time in foster

care because of their mother's substance abuse. The mother has had periods of sobriety. While pregnant with the deceased, the mother relapsed and enrolled herself in an inpatient treatment program, however, she used crack cocaine when she left the program on a pass. Following the child's death, the mother was indicated for substantial risk of physical injury to the two children in her care (her other two children are now adults) and an intact family case was opened. The OIG reviewed records in this case.

Case #111 **DOB March 1987** **DOD March 2003**
Age at death: 16 years
Substance exposed: no
Cause of death: acute respiratory failure due to pneumonia
County: Fulton
Narrative: Sixteen-year-old medically complex ward died in the hospital after being transferred there from his residential care facility with a temperature of 102 degrees Fahrenheit. He had been taking antibiotics for pneumonia. Prior History: The teenager entered foster care in February 1999 as a dependent child because his mother could not care for him. He resided in the same residential care facility since that time. The thirty-eight-year-old mother has three surviving children and no history of child abuse or neglect on record with DCFS. The OIG conducted a preliminary review of this case.

Case #112 **DOB March 1987** **DOD March 2003**
Age at death: 16 years
Substance exposed: no
Cause of death: brain tumor (unconfirmed)
County: St. Louis, Missouri
Narrative: Sixteen-year-old died in the hospital from a brain tumor. Her parents were with her at the time of her death. Prior History: The family's prior involvement with DCFS involved the teenager's cousins. Her fourteen-year-old cousin was indicated in April 2002 for the sexual abuse of his nine-year-old sister while at the teenager's home. The teenager's parents were not indicated for any abuse or neglect. Both cousins were subjects of an intact family case with their mother. The case was opened 8/24/01 following an indicated report of environmental neglect. The case was closed 11/3/03. The OIG conducted a preliminary review of this case.

Case #113 **DOB August 2002** **DOD March 2003**
Age at death: 7 months
Substance exposed: yes, opiates
Cause of death: anoxic encephalopathy due to prematurity
County: Cook
Narrative: Seven-month-old medically complex ward was taken to a hospital clinic for a regular appointment to check the infant's g-tube. The infant slept in the car on the way to the clinic. While taking off the infant's jacket upon arrival at the clinic, the foster mother noticed the infant was limp, and she called out for assistance. A doctor attempted to resuscitate the child, but was unsuccessful. Prior History: The infant tested positive for opiates at birth, and the mother admitted to consistent use of heroin. The infant was born prematurely with numerous medical problems and was in the intensive care nursery for three months. In November 2002 when the infant was ready for discharge, the hospital made a report of medical neglect because the thirty-one-year-old mother and thirty-three-year-old father refused to go to the hospital to learn how to take care of the infant's medical needs. The infant was taken into custody, the parents were indicated for medical neglect, and a case was opened. The baby was placed at a residential care facility until February 2003 when he was placed in the specialized foster home of the woman caring for him at the time of his death. The parents and three siblings of the baby, ages 6, 9, and 13, could not be located by the private agency upon their receipt of the case, though they continued a diligent search. The agency located the family through the Board of Education and was given an address

of a motel. Shortly after the death of the baby, the family left the motel and gave no forwarding address. The case was closed in June 2003. The OIG reviewed records in this case.

Case #114 **DOB January 2003** **DOD March 2003**
Age at death: 2 months
Substance exposed: no
Cause of death: congenital heart disease
County: Cook
Narrative: Two-month-old infant was brought to the hospital by her twenty-three-year-old mother and her twenty-two-year-old father for shortness of breath. The infant was pronounced dead at the hospital. She had been diagnosed at birth with a heart murmur and enlarged heart. At the time of her death, the infant had a burn on her leg. The family reported that the burn occurred approximately one week earlier when the infant became fussy and her father attempted to pick her up while holding an iron. A DCP investigation was conducted and the burn was determined to be accidental, however, the parents were indicated for medical neglect because they didn't have the burn treated and the child had shown signs of trouble breathing over several days without being taken to a doctor. An intact family case was opened as the parents have three surviving children, ages 1, 3, and 4. Prior History: There was an unfounded report in March 2002 on a sibling of the deceased. The three-year-old child's father contacted the hotline alleging burns to the child's mouth, welts to his back, and that the child was very dirty. The child protection investigator found no signs of injury to the child who appeared clean and well-cared for. The OIG reviewed records in this case.

Case #115 **DOB March 2003** **DOD March 2003**
Age at death: 3 weeks
Substance exposed: yes
Cause of death: sepsis due to methicillin resistant staphylococcus aureus
County: Cook
Narrative: Three-week-old infant was found unresponsive by his mother in the early morning and transported by ambulance to the hospital where he was pronounced dead. Prior History: The infant was born substance-exposed and an investigation of the mother for substance misuse was pending at the time of the infant's death. Two weeks after the infant's birth, a second investigation was initiated after the Department received a report of environmental neglect in the mother's home. The mother had two older children, ages 14 and 12. The fourteen-year-old was in the private guardianship of her grandmother. The twelve-year-old lived with her mother and baby brother. The mother was a drug user and seller who agreed to enter drug treatment. The investigator made a safety plan for the maternal aunt to care for the infant until mother entered substance abuse treatment. The maternal aunt worked, so the investigator allowed the mother to care for the infant during the day. The night the infant died, he was sleeping at his mother's home. The infant had not been to a doctor since his release from the hospital. If he had been taken to the doctor, his illness may have been recognized and treated. The mother was indicated for substance misuse, environmental neglect, and substantial risk of physical injury to the surviving daughter in her custody. The twelve-year-old remains in her mother's custody (the State's Attorney's Office declined to pursue custody of her) and the family is receiving intact family services. The investigations were handled by a private agency and the investigator and supervisor were let go following this case. The OIG reviewed records in this case.

Case #116 **DOB March 1988** **DOD April 2003**
Age at death: 15 years
Substance exposed: no
Cause of death: acute bronchopneumonia due to duchenne muscular dystrophy
County: McHenry
Narrative: Fifteen-year-old child was transported by ambulance to the hospital where he was pronounced dead. He had been having trouble breathing for the past few days and, his thirty-two-year-old mother was

treating him with albuterol per his doctor's recommendation. A DCP investigation of the child's death was unfounded. Prior History: There were two prior investigations involving this family. An August 1999 report of inadequate supervision was indicated against the mother for allowing her two-year-old daughter to walk away from her residence unsupervised on two separate occasions. A May 2002 report of medical neglect was unfounded against the mother and twenty-eight-year-old step-father to an eight-year-old child in the home who also suffers from muscular dystrophy. The mother and step-father have four surviving children, ages 3, 6, 10, and 12. A child welfare case was open from April 2003 to September 2003 to provide preventive services. The OIG reviewed records in this case.

Case #117 **DOB April 2002** **DOD April 2003**
Age at death: 1 year
Substance exposed: not tested, but mother has a history of substance abuse
Cause of death: prematurity
County: Winnebago
Narrative: One-year-old medically complex child died in the hospital, where she had been treated since birth. The child was born prematurely at twenty-four weeks gestation. She was one of twins born to her twenty-six-year-old mother. Her twin died shortly after birth. Prior History: This family's first contact with the Department was in April 2000 when the mother was indicated for substantial risk of physical injury to her three-year-old son. An intact family case was opened, but it was closed in October 2001 because the mother was not participating in services. In June 2002 the mother was indicated for cuts, welts, and bruises to her five-year-old son and the intact family case was reopened. This case was still open at the time of this child's death. There was also a pending report of substantial risk of physical injury to the deceased based on the mother's inappropriate interactions with the child at the hospital, such as showing up high, saying mean things, and feeding the child soda through a straw, even though she was not to have anything by mouth because she was fed through a G-tube. Protective custody was taken of both children in April 2003. The surviving sibling remains in foster care. He has a goal of return home. The OIG reviewed records in this case.

Case #118 **DOB January 1999** **DOD May 2003**
Age at death: 4 years
Substance exposed: no
Cause of death: malignant Rhabdoid tumor of the kidney
County: Macon
Narrative: Four-year-old died from a rare form of cancer. She died in her foster home with hospice care. Prior History: The child entered foster care at three months of age in April 1999. She was born medically complex, and her mother was indicated for substantial risk of physical injury because she was unable to care for her. The child was placed in only one foster home, the home in which she died. The biological mother has three other children for whom she is caring. She has not been indicated on any further reports. The OIG conducted a preliminary review in this case.

Case #119 **DOB June 1998** **DOD May 2003**
Age at death: 4-1/2 years
Substance exposed: no
Cause of death: cardiac failure due to complex congenital heart disease
County: Peoria
Narrative: Four-and-a-half-year-old medically complex ward was playing in his crib when his foster parents noticed his oxygen saturation levels were low. They suctioned the child and called 911. The child was pronounced dead at the hospital after being transported there by ambulance. Prior History: Darrell was born with multiple medical problems. His twenty-four-year-old mother, who had previously given up two children, knew she could not care for him and signed over custody and guardianship to her mother's boyfriend. In February 2000, the guardian and the child's mother were indicated for substantial

risk of physical injury to the child, and he entered foster care. His mother visited him regularly and was working toward his return home; it was hoped this could occur in August 2003. The ward had only been living in his final foster home for seven days when he died. His foster parents, who have been licensed since 1994, had been trained on how to care for him, and there were no concerns about his quality of care. The OIG conducted a preliminary review in this case.

Case #120 **DOB March 2003** **DOD June 2003**
Age at death: 3 months
Substance exposed: no
Cause of death: bronchopneumonia
County: Cook
Narrative: Three-month-old infant was found unresponsive by her twenty-year-old mother following a nap. She was transported to the hospital by ambulance where she was pronounced dead. The infant died from bronchopneumonia, a common and often undetected illness in infants. At the time of her infant's death, the mother and her two children were staying at her grandmother's home because two days prior she was robbed at gunpoint in front of her apartment building. Prior History: The infant's mother was a ward of DCFS. She had been a ward since August 1998, and she was in an independent living program since July 2001. The infant had been receiving routine medical care. The mother's guardianship was terminated in October 2003 when she turned 21. She has one surviving child, a son who is four years old. The OIG conducted a preliminary review of this case.

Case #121 **DOB November 1999** **DOD June 2003**
Age at death: 3-½ years
Substance exposed: no, however, mother has a history of substance abuse
Cause of death: neuroblastoma
County: Hamilton
Narrative: Three-and-a-half-year-old ward died from neuroblastoma (a malignant tumor composed of neuroblasts, embryonic cells from which nerve cells develop, occurring most commonly in infants and young children). The child was diagnosed with the illness in October 2001 and was treated for the illness since that time. He underwent two surgeries, a stem cell transplant, chemotherapy, radiation, and multiple other drug therapies. He spent a lot of time in the hospital and at Ronald McDonald House. Prior History: An intact family case was opened in February 2002 to provide preventive services to the family because of the child's illness. In April 2002 the child became a ward of DCFS after his mother was indicated for substantial risk of physical injury to him after she purposely rammed her car into her ex-husband's parked car while the child was in the back seat of her car. The child was placed with his aunt who was a registered nurse. She cared for him until his death. The OIG conducted a preliminary review of this case.

Case #122 **DOB December 1985** **DOD June 2003**
Age at death: 17 years
Substance exposed: unknown, mother has history of substance abuse
Cause of death: acute myeloid leukemia
County: Cook
Narrative: Seventeen-year-old ward died in the hospital where he had been for the past month. The ward suffered from leukemia, which was diagnosed in November 2002. A bone marrow transplant in March 2003, in which his sister was the donor, was unsuccessful. The ward's adult brother and maternal aunt were with him at the time of his death. Prior History: The ward and two of his siblings became wards of the Department in July 1998 after three reports of neglect since May 1996 because of mother's substance abuse. The siblings, ages 16 and 18, remain wards of DCFS. The OIG conducted a preliminary review of this case.

GENERAL INVESTIGATIONS

GENERAL INVESTIGATION 1

ALLEGATION A Department clerical employee collapsed from extreme alcohol intoxication while attempting to board a city bus. The employee's eight year-old grandnephew and six year-old grandniece were in her care at the time of the incident.

INVESTIGATION The Department employee had assumed guardianship of the two children from her niece five years earlier following an indicated report against the niece for inadequate supervision. Three years later, the employee was the subject of a child protection investigation after she sent the two children to their mother's house in the care of a 12 year-old female relative at a time the outdoor temperature was five degrees Fahrenheit. During the investigation, the 12 year-old girl stated the employee told them to take the bus, however after the children missed it they decided to walk the 22 blocks between the two homes. As a result of exposure to the cold, the grandniece suffered frostbite to her fingers. When asked why the employee did not accompany the children, the 12 year-old stated she believed she was "too tired." The child protection investigator indicated the employee for inadequate supervision and risk of harm and referred her for an alcohol assessment. Although the investigator worked in the same Department office as the employee and raised the possibility of a conflict of interest to her supervisor when she was assigned the case, the supervisor was instructed by the chief administrator of child protection investigations that the case would not have to be transferred to another region because the employee was a clerical worker and not another investigator.

One month later, a second investigation, conducted by the same investigator, was initiated after the children started a fire in the home while the employee was asleep in another room. The relative who discovered the fire and made the hotline report told the investigator the employee was intoxicated when the children set the fire and was "drunk almost all the time." The investigator recorded that during their interview in the home the following day, the employee began slurring her words and appeared to be under the influence of alcohol. The investigator determined at that time the children required immediate removal from the home and took them into protective custody. The employee screamed at the investigator and had to be physically restrained by other family members. The report was indicated for inadequate supervision and risk of harm, the children were placed in a non-relative foster home and the case was referred for services through a private agency.

The employee enrolled in a substance abuse program which required her to submit to random drug screenings. In addition, she participated in an alcohol abuse peer counseling program and engaged in parenting classes through a second private agency. The employee completed the programs successfully and was granted unsupervised daytime visitation by the court. One month later, the court granted unsupervised overnight visits. It was during an overnight visit two months later that the employee collapsed while attempting to board the bus with the two children. The employee was taken to a hospital emergency room where her blood alcohol level registered at .405, high enough to potentially induce a fatal coma. A child protection investigation was conducted, this time by an investigator from another region. The investigator indicated the report for inadequate supervision and unsupervised overnight visits were discontinued, however the permanency goal for the children remained to return them to the employee's home.

After the employee had completed five months of continuous compliance with services the court allowed unsupervised overnight visitation to resume. Although concerns were raised regarding the employee's level of participation in peer group alcohol counseling, involved child welfare professionals determined the children should be returned home and recommended the case move towards closure. Following the children being placed back in the employee's home, the caseworker began making unannounced visits and the

employee continued to submit to random drug screenings. Eight months after the incident on the bus, the court ordered the case closed based on the positive reports of the home visits and the negative results from the drug screenings.

Just prior to the Department closing the case, the OIG learned the private agency that provided the employee's parenting classes and was responsible for her drug tests had begun contracting with a different laboratory for urinalysis one week after the children were returned home. The OIG found that the newly contracted laboratory did not automatically screen for alcohol as part of their toxicology tests as the previous lab had done. In an interview with the OIG, a private agency worker involved with the case expressed the erroneous belief that other information provided in the test results indicated the absence of alcohol in the Department employee's system. In a separate interview, a worker in the private agency's toxicology division stated to the OIG that the newly contracted laboratory only tested for the presence of alcohol if specifically requested to do so by the agency. The toxicology worker stated the failure to test for alcohol in the employee's system represented a clerical error by private agency staff.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. OIG investigation #971365 completed on December 31, 1998, recommended that drug screens should include the use of breathalyzers to test for alcohol. The OIG reaffirms this recommendation made four years ago. Each child protection office should have a breathalyzer available and an intact family worker trained to administer it. Breathalyzers can be purchased for approximately $350.00.

The Department has concerns associated with equipment and training necessary for implementing this recommendation. However, the Department agrees that in cases involving severe alcoholism, the Department needs to have appropriate equipment and expertise to enable it to service and monitor such cases. The Department will explore alternative protocols to facilitate access to breathalyzers.

2. If urine drops are used in conjunction with breathalyzers there should never be more than 12 hours notice before a drug drop is submitted. In addition, the days and times of alcohol tests must vary to avoid testing patterns.

The Department agrees to amend policy according to what the appropriate professionals recommend.

3. The Department should pursue counseling for the chief administrator of child protection investigations because of her failure to adhere to Department Procedures Section 300.70 (e).

The issue was addressed with the administrator.

4. The OIG reiterates the recommendation made in investigation #010142 completed on March 1, 2002, that SCR should be instructed that a hotline call involving any Department employee, including clerical staff, must be sent for mandate as well as the full investigation to a county other than the one in which the employee works.

When a hotline report is made and the worker is aware that the individual is a Department employee, the call is referred to the administrator or assistant administrator of SCR. The administrator then contacts the associate deputy of child protection for appropriate out of region assignment. The SCR administrator will send a memo to the associate deputy director of child protection to clarify this issue.

5. The OIG will share a redacted copy of this report with the private agency that provided services to the family and the private agency responsible for overseeing the employee's drug testing.

The Department agrees. The OIG shared the report.

GENERAL INVESTIGATION 2

ALLEGATION

A teacher who had been indicated for sexually abusing his eight year-old daughter remained in his position after the school where he was employed was not informed of the indicated finding.

INVESTIGATION

A child protection investigation was opened after the hotline was called to report that an eight year-old girl had disclosed her father had touched her near her genitals on more than one occasion. The report was indicated against the father for sexual molestation of his eight year-old daughter and risk of harm to his six year-old son. When the OIG received the complaint, it was learned local police had determined criminal charges could not be pursued because the eight year-old could not provide evidence that her father had touched her for the purpose of sexual arousal or gratification. The OIG contacted local police to seek review of the charge determination. After reviewing the information of the case, the chief of police determined charges could be pursued. The father was arrested and charged with four counts of Aggravated Criminal Sexual Abuse. The father subsequently pled guilty to one count of Aggravated Criminal Sexual Abuse Against Family and has registered as a sexual offender.

An intact family service case was opened and a safety plan was implemented which barred any contact between the two children and their father. The children's mother was informed that her husband was prohibited from living in the home or having any unsupervised contact with the children. The OIG contacted the Department administrator in charge of the division of child protection investigations to inform him of the father's profession. The administrator stated the father had never been questioned about his occupation during the course of the previous investigation. The administrator notified the school district pursuant to Department Rule. The state Board of Education revoked the father's teaching certificate.

While the children continued to reside with their mother, staff at the private agency handling the family's intact case determined limited contact could resume between the father and his children provided all interactions were supervised by the caseworker. During a support group counseling session, the mother informed her therapist that the caseworker had permitted the visits to occur without supervision. The mother claimed she and the caseworker had entered into an "agreement" allowing the mother to supervise the visits. A subsequent child protection investigation into the unsupervised visits resulted in indicated finding against the mother, father and the caseworker for risk of harm.

An OIG review of the caseworker's personnel file and background found she had previous convictions for impersonating an attorney and retail theft. It was also learned the caseworker had previously been a Department employee but was discharged for falsification of official correspondence and conduct unbecoming a Department employee. Her personnel file noted the caseworker was ineligible to be rehired by the Department. The caseworker's personnel file with the private agency contained two letters of recommendation ostensibly written by Department employees. In separate interviews with the OIG, both Department employees denied writing the letters. As a result, the OIG issued child welfare employee licensure charges against the caseworker to revoke her license. The caseworker agreed to a voluntary revocation of her license.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Department Procedures 300 should be revised to require child protection investigators collect and document information on the alleged perpetrator's access to children, current employment, and family resources and income.

The Department agrees. Department Procedures 300.50 were revised.

2. The private agency should review and revise its hiring practices to promote more careful decision - making in the future.

The Department agrees. The OIG shared the report with the agency and the Inspector General met with agency management and a member of the Board of Directors to discuss the report. The agency reviewed and revised its hiring practices to include disclosure of residence and work history for the past 10 years and verification of employment for the past 5 years.

GENERAL INVESTIGATION 3

ALLEGATION

A man approved as a childcare provider for a five year-old girl in accordance with Department Rules and paid by the state for providing such care had previously been convicted of rape and indecent liberties with a child. In addition, the man had an outstanding warrant in another state for a parole violation.

INVESTIGATION

The five year-old girl had been removed from her mother's custody and placed in the care of her maternal great aunt through a private agency. The aunt was a single working mother and requested supplemental child care funds from the Department to pay for additional assistance. The aunt presented the man, a family friend, as a candidate to provide childcare. The Department application to receive childcare funds requires a Child Abuse and Neglect Tracking System (CANTS) check. The Department does not require a criminal history check and none was performed. The man was approved to receive the funds and served as the girl's childcare provider.

The OIG conducted a Law Enforcement Agency Database System (LEADS) check of the man. The LEADS check revealed the man had an extensive criminal history including a rape conviction as well as his imprisonment in 1982 related to indecent liberties with a child. An OIG investigator contacted the private agency and related the man's history to a supervisor. The supervisor agreed to immediately remove the girl from the man's care. The OIG investigator also notified the hotline to report risk of harm to the child. The report was subsequently indicated against the man. The aunt was officially notified the Department would no longer approve childcare payments to the man.

The OIG contacted a parole officer in the state where the warrant was issued and determined the man was still being sought. The OIG alerted local police to the man's status and provided his current address. Based on information provided by the OIG, the man was apprehended and extradited to the other state.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Appendix E of Department Procedure 359 (Authorized Child Care Payments) should be amended to require a criminal history check, in addition to a child abuse check prior to approval of employment related childcare for our wards.

The Department agrees. Appendix E of Department Procedure 359 has been amended.

GENERAL INVESTIGATION 4

ALLEGATION

A child protection investigator had two pending criminal complaints against him for molesting teenage females, one of whom was a 14 year-old ward of the Department.

INVESTIGATION

The 14 year-old female ward moved into an apartment rented by friends in a building owned by the investigator. In an interview with the OIG, the girl cited numerous occasions when the investigator hugged, grabbed or attempted to kiss her. A few weeks after she moved in, the investigator confronted the girl with personal information he had obtained from her confidential Department records. Although the girl was an underage ward residing in his rental property, the investigator did not immediately inform the girl's caseworker of her whereabouts. The girl stated the investigator invited her to move in with him and informed her she would not be required to have sex with him if she accepted the offer. The girl stated the investigator was frequently intoxicated and often asked her to retrieve beers for him from the downstairs of the building. She was positive he was aware of her age because he had known her for several years as a friend of his former live-in girlfriend's daughters. A domestic violence incident in which the investigator shoved and hit his girlfriend's daughters resulted in the indicated report against him.

At the same time, a client of the Department who had lost custody of her daughter filed criminal charges against the investigator for sexual assault. In an interview with the OIG, the woman stated the investigator had approached her at a Department office and offered her a place to stay. The woman accepted the invitation and stayed for two nights. The woman stated the investigator frequently abused alcohol in her presence. During the course of this investigation, the OIG interviewed three other women: the ward's 17 year-old housemate, an adult Department client and a neighbor. All three provided similar accounts of unwelcome advances, aggressive behavior and alcohol abuse.

The investigator declined an opportunity to be interviewed by the OIG. A review of the investigator's interview with the state police found several admissions of inappropriate behavior including kissing the 14 and 17 year-olds and having them sit on his lap. The investigator acknowledged to the state police he was aware the 14 year-old was a ward of the state.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue discharge of the investigator.

The Department agrees. The employee was discharged.

GENERAL INVESTIGATION 5

ALLEGATION

A man whose fiancée was attempting to adopt three relative foster children alleged that his former wife, a Department employee, misused her position by alleging risk of harm to his fiancée's three foster children in an effort to obstruct completion of the adoption.

INVESTIGATION

The Department employee had contacted the private agency's foster care supervisor and stated her former husband had a bad temper and had been the subject of an indicated report for physical abuse against their son three years earlier. The employee provided the State Central Register (SCR) number of the report that resulted in the indicated finding. The private agency had already completed multiple background checks on the father through the Child Abuse and Neglect Tracking System (CANTS) and the Law Enforcement Agency Database System (LEADS) which reported no evidence of past violations.

When the OIG received the complaint against the employee, the private agency had already permitted the fiancée to adopt her three foster children. The OIG learned however that the prior background checks had used the man's name and not the SCR number. A check of the SCR revealed an indicated report of abuse of the Department employee's son by an "unknown" perpetrator with the man's same first name. When a hotline allegation is made against a Department employee, or a member of an employee's immediate family, it will initially be coded as "unknown unknown" to preserve confidentiality. The actual name, however, should be substituted whenever an allegation is indicated. The SCR administrator acknowledged the clerical error. The OIG ensured the SCR entry was corrected to show the man's full name. The complaint against the employee was found to be without merit. The Department was unable to reverse the adoptions.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The CANTS system needs to be corrected to show the man's correct name as the perpetrator of the abuse and the transfer of the case into the SACWIS system needs to also reflect the correct name of the perpetrator.

The State Central Register system has been updated to show the perpetrator's name.

2. Child protection investigators and supervisors should be reminded of the importance of updating names and dates of birth in the SACWIS system before abuse and neglect reports are finalized.

A reminder will be sent by the Deputy Director of Child Protection by February 1, 2004.

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

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

GENERAL INVESTIGATION 6

ALLEGATION

A Department employee misappropriated sick days in order to conduct consulting business for a private firm.

INVESTIGATION

As Ethics Officer for the Department, the Inspector General is responsible for reviewing the Statements of Economic Interest submitted annually by Department administrators. The purpose of the statements is to ensure that Department administrators are not involved in financial arrangements that might compromise their professional responsibilities or create the appearance of a conflict of interest.

During this review, the OIG determined that 16 days of sick time the Department employee had requested in order to care for an ill family member were actually used to perform consulting duties for a private firm. The employee received $18,000 in compensation in exchange for her work conducted on personal and family sick days. Department Rules state sick days may only be used to address personal or familial illness or disability, treatment by or consultation with a medical professional or the death of an immediate family member.

The OIG forwarded the information to the employee's supervisor. The supervisor determined the employee should reimburse the Department in an amount equal to what she received for the sick days. Once the money is repaid, the 16 days will be converted to unauthorized absences reflected in the employee's personnel file.

The OIG referred the matter to the Illinois Attorney General for consideration of charges of official misconduct.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue discharge of the employee.

The employee was discharged.

GENERAL INVESTIGATION 7

ALLEGATION

A private agency employee used a Department computer during work hours to access pornographic websites.

INVESTIGATION

The OIG reviewed the employee's time sheets as well as logs of his internet and email usage. An OIG review of the employee's personnel record found that he had signed a Department Information Technology Certificate of Understanding, acknowledging the Department's right to monitor his internet usage and agreeing to access only sites directly related to state business. In an interview with the OIG, the employee admitted using his state computer and internet capability to access pornographic websites. Following the interview, the employee contacted the agency's executive director and resigned his position, effective immediately.

The employee had entered into an agreement with the private agency allowing the employee to take time off, with pay, in order to participate in classes to prepare for the bar exam. In exchange, the employee agreed to reimburse the agency for the time spent in the classes if he resigned his position prior to a particular date. At the time the resignation was tendered, the employee had not served until the date stipulated in his agreement with the agency and had not sat for the bar exam.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Management of the private agency should reiterate to its staff the necessity of restricting the Department domain, e-mail and internet to work related use.

The Department agrees. The OIG shared the report with the private agency. Private agency staff have been instructed accordingly.

2. The private agency should make all attempts to recoup funds advanced to the employee pursuant to the terms of the agreement.

The Department agrees. The private agency is in the process of recovering the money from the former employee.

3. Management of the private agency should consider implementing an e-mail and internet monitoring system to ensure that use of the Department domain is limited to work related access.

The Department agrees. The private agency has implemented an internal monitoring system.

GENERAL INVESTIGATION 8

ALLEGATION

A Department employee maintained a personal file on his work computer that contained extensive sexually explicit internet chat room conversations with a minor.

INVESTIGATION

The computer file consisted of internet chat room conversations between the employee, who used a pseudonym, and numerous females. Three of the females involved identified themselves as being under the age of 18. The employee identified himself as being under the age of 18 when communicating with these minors. The OIG forwarded the information to the state police.

The state police identified one of the chat room participants, a 16 year-old girl from another state. In an interview with state police, the girl stated the employee had led her to believe he was a 17 year-old boy. The girl stated the employee initiated contact with her early one morning through an internet chat room specifically geared towards teenagers. The girl described the employee's communications to state police as being "nasty" because the subject matter was consistently "sexual and weird." The girl stated she was upset by her communications with the employee because during each of their four or five contacts, he directed the conversation towards sexual subject matter.

In an interview with state police, the employee denied engaging in any chat room conversations and stated his wife frequented chat rooms on their home computer in an attempt to improve her English, which was not her first language. The employee stated he saved the conversations and brought them to work in order to monitor his wife's chat room activity. In a separate interview with state police, the employee's wife denied engaging in the chat room conversations and stated she did not possess the knowledge or ability to operate a computer. Based on the interview, police investigators determined the employee's wife had such a limited understanding of the English language it was unlikely she could have been the author of the transmissions. The state police did not charge the employee because he had not arranged to meet with any of the underage girls. The case was closed and returned to the OIG for administrative action.

In an interview with the OIG, the employee provided a different account of how the chat room files appeared on his work computer. The employee stated he had brought a computer disk from home for a co-worker to use since disks were unavailable in their office. The employee stated the disk contained the chat room conversations and that he downloaded the files from the disk to the desktop on his computer to clear space for a work-related project. The employee acknowledged engaging in the chat room discussions but stated he only did so in an effort to improve his English and that he would participate in any conversation in order to practice his language skills. In an interview with the OIG, the employee's supervisor stated computer disks were available in the office and there was no need for workers to provide their own disks.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue discharge of the employee for engaging in conduct unbecoming a Department employee.

The Department agrees. The employee was discharged.

GENERAL INVESTIGATION 9

ALLEGATION

A Department employee whose Illinois driver's license had been revoked used another individual's information in order to obtain a fraudulent license from another state.

INVESTIGATION

An OIG review of the employee's driving record found the employee's Illinois driver's license was initially suspended nine years ago for driving under the influence of alcohol and then was revoked following his second offense one year later. An additional suspension of his license was added six years ago for his failure to pay outstanding parking tickets. Two years ago, further action was taken against the status of the employee's license when it was learned he had attempted to obtain a fraudulent Illinois driver's license using another individual's personal information.

The employee later used the same individual's personal information in order to successfully obtain a driver's license in another state. The Illinois Secretary of State's Office became aware of the fraud when the individual whose information was used attempted to renew his own license and was asked to relinquish his out of state license. The OIG contacted the other state's Department of Motor Vehicles which confirmed the employee had obtained a fraudulent driver's license under an assumed identity.

The OIG made numerous attempts to schedule an interview with the employee, including requesting the intervention of the employee's supervisor. The supervisor was unable to make direct contact with the employee and informed the OIG he had ceased reporting to work. An OIG review of staff attendance reports from the office found the employee was listed as being "unauthorized absent" for three weeks following his being contacted by the OIG. Despite repeated requests from the OIG and Department rules requiring compliance with OIG investigations, the employee failed to make himself available for an interview.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue discharge of the employee for conduct unbecoming an employee, unexcused absences, and failure to cooperate with an OIG investigation.

The employee resigned with no reinstatement rights.

GENERAL INVESTIGATION 10

ALLEGATION

A Department administrator accepted a personal loan from a man who is a licensed foster parent and both the husband and father of Department contractual employees.

INVESTIGATION

In an interview with the OIG, the lender stated he knew that the Department administrator worked for the Department but was unsure in what capacity, and that he had met the administrator through his wife, a Department foster parent support specialist. The lender stated he had been asked by his wife to lend the money and that the administrator was to repay him "whenever she could." The lender produced a simple, two-sentence document signed by both parties stating the amount of the loan and a promise to settle the debt without interest. The document was not notarized or certified in any way.

In her interview with the OIG, the Department administrator stated the $3500 interest-free loan was a gesture of assistance made by a friend during a period of personal financial hardship. The administrator denied requesting the loan but acknowledged she had discussed her monetary problems with the lender's wife. The administrator stated she had no professional relationship with the foster parent support specialist and, as a rule, would recuse herself from any case involving people she "knew." The administrator did not discuss the loan with any other Department personnel and stated it "never occurred" to her that any aspect of the arrangement could be problematic. The administrator told OIG investigators she was unfamiliar with the Department rule regarding conflicts of interest.

Prior to the loan being made, the daughter of the lender and the foster support specialist was awarded a Department contract to provide services to the administrator's adoptive children. The administrator recommended the daughter for the contract and supervised her work. The contract was still in effect at the time the loan was made. The OIG referred the issue of the loan to the Department's Conflict of Interest Committee which determined the loan did in fact constitute a conflict of interest in violation of Department rules.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department administrator has been found to be in violation of Rule 437, sections 437.40 (a), (e), and (f). The administrator violated these sections by accepting a personal loan from the lender, a licensed foster parent with the Department and the spouse of a foster parent support specialist. The Department administrator has a duty to be aware of the rule regarding conflicts of interest. The administrator should be appropriately disciplined for this violation.

The Deputy Director of Clinical Services discussed this issue with the administrator prior to the release of the OIG report. As a result, formal discipline could not be imposed.

2. The lender and the foster parent support specialist should receive ethics counseling so that they may understand why their actions, while well-intentioned, created a conflict of interest.

The OIG Ethics staff counseled the lender and the foster parent support specialist.

3. Because of the ongoing conflict of interest issues between the administrator and this family, the OIG stands by its previous recommendation that the Department's contract with the couple's daughter be terminated.

The Department agrees and the contract was terminated.

GENERAL INVESTIGATION 11

ALLEGATION

A Department attorney acted as legal counsel for his brother-in law and his spouse who were subjects of a child protection investigation.

INVESTIGATION

The parents were the subjects of a hotline report alleging abuse against their 17 year-old daughter. The anonymous reporter stated the father had threatened to kill the girl and the mother had cut her on the arm with a knife. The hotline call was accepted and a child protection investigation was initiated. The assigned child protection investigator worked in the same office as the Department attorney. In separate interviews with the OIG, both the investigator and her supervisor acknowledged they knew the Department attorney but were initially unaware of his relationship to the parents.

In his interview with the OIG, the Department attorney stated the mother, his wife's sister-in-law, contacted him the morning after the hotline call was made and informed him of the pending investigation against her and her husband. Following the phone call, the attorney then checked the Department computer system in an attempt to learn the identity of the investigator assigned to the case, an act which he acknowledged to the OIG was a breach of Department policy. The attorney then spoke to the child protection investigator's supervisor and informed him of his relationship to the parents and requested that the investigation be transferred out of the office. The supervisor told the attorney the assigned investigator was very capable and refused to transfer the investigation. The attorney did not speak with his own supervisor to discuss the potential conflict of interest inherent to the circumstances of the investigation being conducted by a worker from his office.

Later that day, the Department attorney encountered the investigator in a hallway of the building and informed her the mother was in his office at that time. The investigator had unsuccessfully traded phone calls with the mother and accepted the opportunity to speak with her directly. The father arrived at the office during the course of the meeting and joined the Department attorney, the mother and the investigator. In her interview with the OIG, the investigator stated that during the meeting the mother identified the Department attorney as the family's counsel. The investigator also stated that during the meeting the attorney produced legal documents he had prepared for the parents authorizing the transfer of guardianship of the girl to her maternal grandparents.

In separate interviews with the OIG, both the mother and the Department attorney acknowledged his role in providing support and guidance in their dealings with their daughter but denied they ever represented him to the investigator as the family's legal counsel. Although both the mother and the attorney stated their meeting in his office that morning had been scheduled prior to the hotline report, they offered conflicting and inconsistent accounts regarding the impetus for that meeting. In addition, the Department attorney acknowledged drafting the guardianship transfer papers.

The child protection investigator decided enough evidence existed to warrant a full investigation and her supervisor transferred the case to another region. The investigator who assumed responsibility for the case subsequently determined the allegation could not be substantiated and recommended the report be unfounded.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department attorney should be disciplined for inappropriately accessing the Child and Youth-Centered Information System (CYCIS) and exercising poor judgment when he failed to notify his supervisor of his role as advisor to the family regarding guardianship issues.

The Department agrees. The Department attorney was given a written reprimand. The attorney's grievance of the discipline was denied by the Department.

2. The child protection investigator's supervisor should be disciplined for failing to recognize and respond to the conflict of interest in a prompt fashion.

The Department and the OIG agreed the supervisor would not be disciplined but instead would use the report as a training tool.

GENERAL INVESTIGATION 12

ALLEGATION

Repeated cases regarding potential or actual conflicts of interest involving Department employees and private agency personnel prompted the OIG to review a number of cases in order to address the issue.

INVESTIGATION

The OIG compiled an anthology of eight cases referred to the office in recent years that were illustrative of various forms of conflicts of interest. Department Rule 437 is a lengthy and detailed explanation of the circumstances that constitute a conflict of interest for Department employees. The Code of Ethics for Child Welfare Professionals also describes the duty to avoid conflicts. Private agencies are required to have ethics codes barring conflicts of interest as well.

An actual conflict of interest arises when child welfare professionals entrusted to exercise objective judgment in the service of clients have an interest, whether personal or financial, that could interfere with the objectivity of that judgment. An individual does not have to act upon the interest, the existence of contradictory motivations is enough to constitute a conflict. One such example involved a caseworker whose daycare provider was also a foster mother on the worker's caseload. After the foster mother became the subject of an abuse and neglect report, the caseworker informed the foster mother of the pending investigation and contacted the involved child protection investigator and advocated on the foster mother's behalf.

A potential conflict of interest occurs when the likelihood exists that events which are about to take place might reasonably affect future decision-making by individuals in positions of authority or responsibility. In the case mentioned above, a potential conflict of interest arose when the daycare provider decided she wanted to become a foster parent. The caseworker could have avoided the potential conflict of interest by ensuring she had no professional involvement with the licensing or management of the day-care provider's activities as a foster parent.

Apparent conflicts of interest occur when a reasonable person unfamiliar with the facts of a situation could infer that a conflict exists. In one case, a child protection investigator was accused of providing information to the proprietor of a bar regarding a child abuse investigation involving another frequent bar patron. Although it was learned the investigator and the subject of the investigation had no personal relationship, the awareness of members of the community at large that they both frequented the same establishment and shared mutual acquaintances contributed to a public perception that a conflict existed.

Although Department Rule 437 requires Department employees to report any perceived conflicts of interest to the Office of Internal Audits for review by the Department's Rule 437 committee, none of the Department cases included in the OIG anthology had been referred. Such behavior suggests a lack of understanding among Department employees about what constitutes a conflict of interest as well as a general absence of awareness of the Rule 437 committee. The Department must take steps to ensure greater familiarity with the parameters of conflicts of interest and what to do when questions regarding the propriety of given situations arise. Similarly, private agency employees in these cases demonstrated a lack of familiarity with the concept of conflict of interest and its impact on professional objectivity.

It is important to identify and address all conflicts of interest, whether actual, potential or apparent. Child welfare clients, agencies and the public must be able to trust that child welfare professionals will make objective decisions regarding the safety and well-being of children and their families. Private interests and relationships should not interfere or appear to interfere with that objectivity. Avoiding and resolving conflicts of interest is an important component of the fiduciary duty of professionals in the child welfare field.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. A redacted version of this report should be distributed to all private agencies for use in their education and training programs on conflicts of interest.

The Department's Division of Clinical Services and Professional Development will incorporate this report into training. The Department will update the OIG quarterly on the status of the implementation of the training needs identified.

2. A redacted version of this report should be employed in CORE and Foundations training modules on conflicts of interest.

The Department's Division of Clinical Services and Professional Development will incorporate this report into training. The Department will update the OIG quarterly on the status of the implementation of the training needs identified.

3. The Department should draft a Conflict of Interest Rule similar to Rule 437 that applies to private agencies. The rule should prohibit multiple relationships and other relevant conflicts of interest within private agencies. The rule should be accompanied by training for private agency staff on conflicts of interest issues and forums for discussing applied ethics issues. The OIG Ethics Office can provide assistance with these efforts.

The Department agrees that there needs to be a provision in provider contracts that is consistent with Rule 437. The Deputy Director for Monitoring and Quality Assurance, in cooperation with the Deputy Director for Budget and Finance, will work to incorporate this into all fiscal year 2005 private agency contracts.

GENERAL INVESTIGATION 13

ALLEGATION

A Department employee filed a false hotline report against his former girlfriend regarding her supervision of their nine year-old son.

INVESTIGATION

The Department employee contacted the State Central Register (SCR) and reported the nine year-old boy's mother consistently left him unsupervised for two hours in the morning before he went to school and another hour in the afternoon before the mother returned home from work. The Department employee bolstered his claim by stating the boy was autistic and was unable to use a telephone, thereby increasing the risk to him of being at home alone. When interviewed during the child protection investigation, the employee described the mother's home as being old and in poor condition.

The child protection investigator interviewed the boy and his mother. The boy told the investigator he was able to use a telephone and knew how to contact his mother at work, demonstrated his familiarity with emergency phone numbers and related contingency plans involving seeking help from neighbors in case of an emergency. The child's therapist stated the boy was not autistic and was an excellent student who was capable of caring for himself for short periods in the home. The investigator also spoke with two of the boy's teachers who concurred with the therapist's assessment of his ability to behave responsibly and follow instructions.

The investigator interviewed the Department employee. During the interview, the employee asked, "You do not know who I am, do you? You will find out who I am." The child protection investigator unfounded the allegation and determined the employee had provided false and misleading information to SCR. The State Central Register classified the case as a false report.

The OIG, learned that on the morning of the day the employee called the hotline he had filed an emergency order of protection against the mother with the custody court alleging inadequate supervision of their son based on the same facts alleged in the hotline call. The custody court had refused to issue the order. The SCR administrator forwarded a complaint to the State's Attorney's Office against the employee for disorderly conduct for filing a false report.

In his interview with the OIG, the Department employee refused to answer most questions posed to him.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue discharge of the employee.

The employee was discharged. The employee's grievance is pending.

GENERAL INVESTIGATION 14

ALLEGATION

The OIG received multiple complaints that a Department caseworker had engaged in inappropriate relationships with clients. The former husband of one client also alleged the caseworker had interfered in his custody battle with his ex-wife over their children.

INVESTIGATION

The OIG investigated the caseworker's relationships with three different women involved with the Department. In an interview with the OIG, the first woman, a pregnant mother of two who had been indicated for inadequate supervision, stated she had never been romantically involved with the caseworker. Both the mother and her boyfriend told OIG investigators that while they felt the caseworker's visits to the home may have been excessive, he had always behaved in a professional manner. In his interview with the OIG, the caseworker stated he visited the home often because the couple had substance abuse issues and he viewed the home as a high-risk environment. The OIG found no evidence of an inappropriate relationship with the mother.

The second woman, a mother of three who had been the subject of an unfounded abuse report, was engaged in a custody dispute with her former husband. In an interview with the OIG, the ex-husband expressed his concern that the caseworker was influencing the custody case and alleged the worker had been attempting to intimidate him by calling his home and driving around his house. The physical description of this person provided by the ex-husband did not match the caseworker and it became clear during the course of the interview he had an inaccurate understanding of the worker's role with the Department. In his interview with the OIG, the caseworker acknowledged dating the woman but stated he had met her through personal ads in a local newspaper and had been unaware of her involvement with the Department. No evidence was found through interviews or a review of the case file to suggest the caseworker met the mother prior to or during the child protection investigation.

In the third case, the caseworker had been assigned to supervise visits between two children and their mother at the home of the mother's sister, the designated relative caregiver. After handling the case for one month, the caseworker was transferred to another field office and the case was turned over to another worker. In separate interviews with the OIG, both the sister and the caseworker acknowledged that the caseworker had spent a great deal of time in the home. The sister stated the caseworker frequently stayed for meals, did his laundry at the house and used her computer. The sister told the OIG that she sometimes, "had to nag [the caseworker] to leave." Both the sister and the caseworker stated that the relationship between them was initially friendly and that it evolved to a more intimate stage after he was transferred from the case. In her interview with the OIG, the sister stated that after an incident when her ex-husband encountered the caseworker at her home and made threats against them and her children, she discontinued the relationship.

In his interview with the OIG, the caseworker stated he had done nothing wrong since the relationship intensified after his transfer. However, the caseworker's practice of socializing with the sister and doing chores at her home created an appearance of impropriety that could adversely affect public perceptions of the Department. Department policy states that employees may not engage in romantic or sexual relationships with clients for a period of two years after the completion of the client's involvement with the Department. The caseworker ignored Department policy and his behavior constitutes a disregard for professional boundaries in violation of Department Rules and the Code of Ethics for Child Welfare Professionals.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The Department should discipline the caseworker for initiating and pursuing a romantic relationship with a client and for failing to notify his supervisor or the court of this relationship.**

The Department agrees. The caseworker is currently on suspension pending discharge.

GENERAL INVESTIGATION 15

ALLEGATION

A child protection investigator brought a friend with her to a foster mother's home while on-call and responding to an off-hours investigation. The foster mother alleged the friend was intoxicated and disruptive.

INVESTIGATION

The child protection investigator was contacted by page after police learned the foster mother had locked her 17 year-old foster daughter out of the home. Upon arriving at the police station the investigator learned the foster mother had taken the action after finding the 17 year-old in bed with a 21 year-old man the night before. The investigator was instructed by her supervisor to take protective custody of the girl and accompany her and police to the residence to retrieve the girl's belongings.

In an interview with the OIG, the investigator stated that at the time she received the page she was attending a movie with a friend. The investigator said that since the two had traveled together she asked the friend to transport her, first to the police station and then to the foster mother's home. The investigator stated the friend waited in the car until she summoned him to help carry some of the girl's possessions out of the home. She refuted the assertion the friend became involved in the incident in any way and denied either of them had consumed any alcohol that evening. In an interview with the OIG, the friend related a similar account of the events and expressed his reservation to take any part in the situation at the home.

In separate interviews with the OIG, the responding police officer, the foster mother's former foster son and a downstairs neighbor who were all present in the home at the time gave varying accounts of the friend's location during the incident and his role in carrying the girl's belongings from the home. All of the witnesses described a contentious, chaotic scene inside the home. The police officer stated he had been in close proximity to the investigator and her friend and did not detect any alcohol on either of them.

Although there was insufficient evidence to support the foster mother's allegations, the investigator demonstrated poor judgment in allowing an unauthorized person to accompany her during performance of her professional duties. The investigator's action violated the basic standard of client confidentiality and exceeded professional boundaries.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be disciplined for bringing her friend into a client's home during an official child protection investigation.

The investigator received a 20-day suspension. The investigator filed a civil service complaint which is pending.

GENERAL INVESTIGATION 16

ALLEGATION

A child protection investigator who called the hotline after witnessing erratic driving by the mother of a two year-old child was assigned to investigate her own report. The mother alleged that she and the investigator had been involved in a mutual traffic altercation and that the investigator had attempted to intimidate her by threatening to take custody of the mother's child.

INVESTIGATION

The child protection investigator contacted the State Central Register (SCR) to report that she had witnessed the drivers of both a van carrying a young child in a car seat and another vehicle engaging in erratic, dangerous driving. The investigator recorded the van's license plate number and provided it to the operator. The investigator stated the behavior could be attributable to either road rage or driver intoxication. The operator accepted the call for investigation. Despite the potential danger of an intoxicated motorist transporting a small child, neither the investigator nor the SCR operator contacted police to report the incident.

Later that day, the case was assigned to the same investigator by her substitute supervisor, with full knowledge that the investigator had made the initial report and was a witness to the incident in question. In separate interviews with the OIG, both the investigator's regular supervisor and substitute supervisor stated they saw nothing improper about assigning a case to an investigator who was also the reporter. The investigator accepted the case and arranged a meeting with the driver of the van.

Two days later, the investigator went to the home of the van driver, the mother of a two year-old child. Upon arriving, the investigator informed the mother of the investigator's authority to remove the child from the home if she found evidence of abuse or neglect. In an interview with the OIG, the mother stated the investigator was in fact the driver of the second vehicle she had the altercation with. The mother stated that, at the time of the incident, the investigator had behaved aggressively and was visibly enraged. The mother stated that when the interview began, she initially had difficulty recalling the incident and that the investigator became noticeably frustrated and angry. The mother said the investigator eventually identified herself as the driver of the second vehicle at which point the mother became upset and anxious out of fear at the realization that the individual who had been so angry with her a few days earlier was now in her home and had the authority to remove her child. The investigator ultimately unfounded the report against the mother. Although questions were raised regarding the investigator's actual role in the traffic altercation, the OIG found insufficient evidence to support the allegation of abuse of power against the investigator.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The SCR administrator should review the tape of the hotline call and discuss it with the call operator to ensure that such calls are treated consistently and without undue deference to the identity of the caller. Protocol should be clear that when a caller alleges that a driver may be intoxicated and driving erratically, the police should be contacted immediately.

The SCR administrator reviewed the tape and discussed it with the operator. The importance of calling police in situations involving criminal activity was clarified for staff. The issue was addressed at supervisors' meetings and subsequent unit meetings. This discussion was documented in the meeting minutes.

2. The Department should issue an immediate memorandum to all child welfare administrators to stop assigning investigations to reporters who observed the abuse or neglect outside of their professional duties.

The Department agrees. The Deputy Director of Child Protection will issue this memorandum by February 1, 2004.

3. The regular supervisor should be counseled concerning the practice of assigning investigations to reporters who observe abuse or neglect outside of their professional duties.

No official counseling session was held as counseling is considered discipline for merit compensation employees. The issue was discussed with the regular supervisor.

4. The Department's public service administrator should counsel the child protection investigator concerning the ethics of her actions in this case.

The investigator was counseled.

GENERAL INVESTIGATION 17

ALLEGATION A mother and stepfather who had been the subjects of an unfounded abuse report against their 15 year-old daughter alleged the child protection investigator assigned to their case abused her authority and exhibited a bias against their religious beliefs.

INVESTIGATION The family became involved with the Department after the girl's school guidance counselor called the State Central Register (SCR) to relate the girl's report that her stepfather frequently used corporal punishment against her. The report was not accepted but the family was referred for services through a private agency. The family did not accept services from the agency but did take the girl to their family physician and a psychiatrist. The psychiatrist referred the girl to a psychologist for counseling. Six days later, the girl was transported by ambulance to a hospital emergency room following an explosive confrontation with the stepfather at his workplace. During this episode, the girl had to be physically restrained by paramedics because of her volatility and had a surgical mask placed on her face at the hospital to halt her from spitting at staff members. The girl was transferred to a hospital in another city and admitted to the adolescent psychiatric unit. The girl was photographed by a police officer and a nurse completed a body chart to document the girl's injuries. Both the photographs and the chart showed the girl had superficial scratches and a few minor bruises to her extremities. The girl reiterated her allegations of physical abuse by her stepfather and the psychiatrist called SCR which accepted the report and opened a child protection investigation.

A child protection investigator from the area where the hospital is located met the mandate to see the child within 24 hours. The girl told the CPI that her stepfather grabbed her by the leg and slammed her down to the ground. The girl stated that her stepfather frequently resorted to physical violence as a means of discipline and that her mother was complicit in the behavior. The investigator assigned to the family case went to the home the following day, but found no one home. In her case notes, the investigator recorded that she did not leave a card at the home because she did not want to alert the parents to the Department's involvement.

The investigator visited the girl's school and talked with the guidance counselor, who stated the girl exhibited much anger and defensiveness and was prone to "go ballistic." The school assistant principal related an incident from the previous year when the girl had become aggressive with other students on the school bus and made racial remarks against them. In her case notes, the investigator recorded the principal's opinion that the girl's parents had instilled her with racist beliefs and included his own observation that this corresponded with the views of the prominent leader of the parents' religious group.

Five days after the girl's hospitalization the investigator made her first contact with the parents. During the interim, the investigator had learned that the parents and their two younger children were out of town attending a religious conference. When the investigator telephoned the parents to arrange a meeting, the mother asked the investigator to wait until that afternoon to visit the home so that her husband and the two younger children would be present. Later that day, the investigator went to the home and spoke with the family. The parents stated the girl presented severe behavioral problems both at home and in school and that her propensity for violent outbursts required physical restraint to prevent her from injuring herself or others. Although the parents informed the investigator of the girl's recent meetings with the two medical doctors and a therapist, the investigator did not ask the parents to sign releases authorizing her to obtain information from the counselor or the physicians. The mother agreed to a temporary safety plan that called for the girl to reside with her natural father after her release from the hospital.

Following the girl's discharge from the hospital, the investigator took her into protective custody and filed an emergency petition for the Department to assume temporary custody. A shelter care hearing was scheduled for two days after the petition was filed. On the afternoon of the day prior to the hearing, the investigator left

a voicemail message for the parents informing them of the hearing, however the parents did not appear in court the next morning. At the hearing, the investigator stated her position that all three children should be removed from the parents' home. When the presiding judge expressed concern about the parents' absence, the investigator stated the parents had prevented her from seeing their two younger children for five days after the case was opened. The investigator also stated that because of the parents' religious affiliation, it was likely they would attempt to hide the children from the Department. The court ordered the Department to take all three children into temporary custody and ruled that the two youngest children could not be returned to their parents without further order from the court. One week later, there was a rehearing on shelter care and the two youngest children were returned to the parent's custody. The investigator ultimately indicated reports of tying/close confinement and mental injury to the girl and risk of harm to the two younger children.

After the adjudication hearing the Judge found the state had not proved its case by a preponderance of the evidence and dismissed the petition. During the adjudication hearing, the investigator testified that she believed she had approached her investigation in an unbiased manner. She denied testifying at the shelter care hearing that the parents, because of their religious beliefs, might conceal the children from the Department.

The parents appealed the indicated finding. Initially the finding was upheld internally. The parents then requested an administrative hearing. The doctors, who had seen the child before the investigation began, said they saw no evidence of abuse. The police officer that took the pictures at the hospital testified that he did not observe any unusual bruises or marks on the girl. The girl testified that at the time of the incident she was out of control and had threatened to kill her parents and siblings. She further testified that her stepfather attempted to physically restrain her on occasions when she hit her siblings or threatened to harm or kill herself. The administrative law judge ruled that the Department had failed to substantiate the indicated allegations and recommended they be expunged. The Director of the Department concurred with the judge's ruling and granted the request for expungement.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should arrange training for the local field office regarding the ethical obligations that a child welfare worker has when involved with court officers and when testifying in court.

The Department agrees. The training was completed.

2. The Department should develop a uniform method of dealing with the Juvenile Court in the various counties so that workers are not allowed to request temporary custody and guardianship orders in the Department when the intention is to leave the children in their biological home. The Department's Legal Division should ask courts to issue orders of protection in such cases rather than temporary custody orders and guardianship orders.

The Department agrees to identify counties where these issues exist and determine what would work best in each particular region.

3. This report should be shared with the private agency where the caseworker's former supervisor is currently employed as she approved the investigation and permitted referral of this case to court.

The Department agrees. The OIG shared the report.

GENERAL INVESTIGATION 18

ALLEGATION

The OIG learned that a former foster mother, who had been the subject of a prior OIG investigation, called the Governor's office and threatened to "blow up" a Department office.

INVESTIGATION

The former foster mother had been the subject of an earlier clinical determination that she was incapable of providing adequate care for her three year-old grandniece. The OIG investigation found the foster mother's biological children had previously been removed from her care as a result of abuse inflicted upon them by her then-husband. The husband's actions had included tying one of the foster mother's sons to a post in the backyard for an entire day and forcing another to lick urine off of the bathroom floor. Throughout Department and law enforcement investigations into these incidents, the foster mother had steadfastly supported her husband's actions and minimized the damaging effect his behavior could have on her children. In addition, the OIG learned the foster mother, a nurse, had pled guilty to unlawful possession of a controlled substance. The OIG also learned she had forged prescriptions to obtain controlled substances. Based on these and other findings of the OIG investigation, the Department supported the private agency's decision to remove the girl from the foster mother's home.

Following the girl's removal, the foster mother began contacting the OIG office as well as other Department and state government offices to protest the decision. During one such conversation with a receptionist in the Governor's office, the foster mother stated, "someone is going to lose it and blow up the DCFS building." The Department referred the threat investigation to Central Management Services (CMS) police. The CMS police interviewed the former foster mother who denied making the threat and attributed the statement to manipulation of telephone lines by the phone company. A CMS police investigator informed the foster mother that she would be prosecuted if she made any further threats against the Department.

In an interview with the OIG, the deputy chief of security for CMS stated he did not refer the matter to the state police because he did not believe the threat was credible because it was not "direct," as the foster mother had not stated that she would blow up the building, only that "someone" might. The OIG ensured that all offices that might have been possible targets for retaliation stemming from the case were notified and provided with recent photographs of the former foster parent.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. This incident demonstrates a security risk and a failure to follow through that falls below a minimum standard of security practice. Future threats and other potential criminal matters should be forwarded to the OIG for assessment and coordination with law enforcement.

The Deputy Director of the Division of Clinical Services and Professional Development will identify how to implement information into training for staff on minimizing security risks. This will be presented to the Director for consideration.

GENERAL INVESTIGATION 19

ALLEGATION

Two Department public service administrators misused the Department e-mail system to send non-work related messages that were often sexual in nature. In addition, one of the administrators frequently communicated directly with other employees in his local field office in a sexualized manner, creating an uncomfortable work environment.

INVESTIGATION

The OIG reviewed hundreds of e-mails sent or received by the first public service administrator. The OIG found a great number of e-mails sent between the administrator and her boyfriend, a state police officer. The transmissions covered a wide array of non-work related subjects including plans to meet and extremely personal information regarding the couple's relationship. The OIG also found numerous e-mails between the administrator and the second public service administrator named in the allegation. Messages between the two administrators contained a continuous banter of sexual innuendo and demeaning sexual terminology.

The OIG interviewed a number of Department employees regarding the behavior of the second public service administrator in his local field office. The employees outlined a consistent, long-running pattern of both suggestive and blatantly sexual language as well as behavior that clearly constituted harassment. Although many employees stated they raised concerns with their superiors regarding the administrator's behavior, the complaints were casually dismissed and the administrator's behavior excused as a character trait. The employees interviewed by the OIG wished to preserve their anonymity and declined to identify which supervisors they addressed these issues with, preventing any disciplinary action being taken against the supervisors complicit in this behavior. The administrator has since retired from the Department.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department's Computer Security Guide should be amended to clarify that egregious abuse of e-mail and the internet including threats, sexual harassment and access to child pornography sites will subject the user to immediate discipline or discharge.

The Department agrees. The Computer Security Guide was amended.

2. This report should be shared with the supervisor of the first public service administrator so that her use of time and e-mail can be properly monitored to ensure that it is for state business purposes, and her supervisor should notify her in writing in conformity with the Department's Computer Security Guide.

The Department agrees. The report was shared with the supervisor.

3. The first public service administrator should be counseled with regard to her complicit behavior with the tone of the e-mails she accepted, responded to, and further distributed, and that as a public service administrator more is expected of her.

The Department agrees. The administrator was counseled.

4. This report should be shared with the supervisor of an executive secretary in the field office to ensure that her future use of e-mail is for purposes of state business only and her supervisor should notify her in writing in conformity with the Department's Computer Security Guide.

The Department agrees. The report was shared with the supervisor.

5. The Office of Employee Services should conduct training in sexual harassment for supervisors and administrators in the field office by June 30, 2003.

The Department agrees. The Office of Affirmative Action conducted mandatory sexual harassment training for all supervisors and administrators in the field office.

6. The Office of Affirmative Action should determine if the climate of sexual harassment that existed in the field office has abated.

The Department agrees. An investigation by the Office of Affirmative Action was completed.

GENERAL INVESTIGATION 20

ALLEGATION

A licensing supervisor forged the signature of a licensing worker and mailed fundraising letters on behalf of a sorority on Department letterhead.

INVESTIGATION

The OIG found no evidence to substantiate either allegation, however during the course of the investigation, the OIG learned the supervisor held a position on the board of directors of a private child welfare agency. An OIG review of the supervisor's personnel file and records from the private agency found she had in fact sat on the board of directors while serving the Department. The agency was within the same region the supervisor was responsible for serving and the supervisor's local field office had licensed the agency to institute a Head Start program. There was no indication in the personnel file the supervisor had made anyone in the Department aware of her role with the agency. The supervisor's immediate superior informed the OIG she was unaware of the supervisor's involvement with the agency.

The OIG referred the matter to the Department's conflict of interest committee which determined the supervisor's dual role was in violation of Department Rule.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. A copy of the letter from the Department's Conflicts of Interest Committee should be placed in the supervisor's personnel file.

The Conflicts of Interest Committee sent a copy of the letter to the supervisor with notification that a copy would be placed in her personnel file.

GENERAL INVESTIGATION 21

ALLEGATION

The OIG investigated an allegation that an identification number assigned to a government attorney who had been provided with a Department computer was used to access the computer during work hours in order to visit non-work related sites on the internet.

INVESTIGATION

An OIG review of the computer's internet log found the employee's identification had been used for successful and unsuccessful attempts to access numerous websites that had no relationship to the tasks and duties performed by the state government office. Internet monitoring software utilized by the Department designated the sites into various categories including; adult/sexually explicit, games, violence, gambling, glamour and intimate apparel and hate speech. The review also identified an inordinate amount of activity involving commercial goods and services providers. The employee had signed an information technology certificate of understanding and agreed to restrict use of his internet connection to work-related activities. The employee's actions in this instance are in violation of that agreement. The OIG referred the matter to the employee's supervisor for disciplinary action.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. This matter should be referred to the employee's supervisor for counseling or discipline as appropriate.

The Department agrees. The OIG referred the issue to the employee's supervisor.

2. The employee's internet access from the Department of Children and Family Services should be terminated.

The Department revoked the employee's internet access.

GENERAL INVESTIGATION 22

ALLEGATION

A Department caseworker did not possess a valid state driver's license as required by her position.

INVESTIGATION

The caseworker's driver's license was revoked following her convictions on two counts of driving under the influence of alcohol five years earlier. At the time, the caseworker did not inform the Department of her loss of license and her supervisor did not learn of the license revocation until two years later. The caseworker's failure to report the revocation and her submission of travel reimbursement requests containing affirmations she was a licensed driver resulted in a 30-day suspension. Since losing her license, the caseworker has also been arrested on one occasion for driving with a revoked license while traveling home from work. The caseworker has initiated five court hearings in an attempt to have her license reinstated or to obtain an employment restricted license, however her requests have been denied each time. During the most recent hearing, the presiding judge cited the caseworker's arrest for driving with a revoked license as part of the basis for denying the request.

Department rules require caseworkers to possess a valid driver's license in order to visit clients' homes, transport children and complete travel-related duties essential to effective job performance. In an interview with the OIG, the caseworker stated she relied on family members to transport her to and from work as well as to her various appointments during business hours. In a separate interview with the OIG, the caseworker's supervisor stated that when the Department learned of the caseworker's license revocation, it was determined she could continue to fulfill her duties. The supervisor stated that the caseworker's relatives or fellow employees were relied upon to drive the caseworker to home visits and other appointments and, on occasions when children on her caseload required transportation, other caseworkers or the supervisor himself would assume responsibility for their delivery. The supervisor stated that the caseworker's prohibition from driving never required reduction of her caseload.

An OIG review of the caseworker's time sheets for a three-month period just prior to initiation of the investigation found that on average, the caseworker spent half as much time in the field as other members of her team. In addition, the caseworker's imposition on her co-workers and supervisor to meet her transportation needs reduces the amount of time they are able to dedicate to their own cases and effectively increases their caseloads. By allowing the caseworker's relatives to facilitate her professional duties, the Department unnecessarily risks revealing clients' confidential information to unauthorized individuals. In addition, the Department has no knowledge of the driving status or criminal history of the caseworker's relatives and is exposing itself to potential liability by allowing members of the public to participate in the execution of official assignments.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The Department should reconsider allowing the caseworker to continue in her present position while she does not meet qualifications necessary to hold that position.**

The caseworker was suspended pending discharge and then returned to work. She was reinstated with restrictions.

2. **The Department should examine the average time spent in the field by workers on the supervisor's team and compare that time to other teams. The Department should assess whether average time workers spend in the field meets the public's expectations of how much direct contact workers have with their clients and collaterals.**

The Department and the AFSCME union have agreed to design a statewide time study by March 1, 2004. The design will also be shared with the OIG.

GENERAL INVESTIGATION 23

ALLEGATION

A Department employee required to provide written proof to support illness-related work absences submitted suspect doctor's notes.

INVESTIGATION

The Department employee had been placed on "proof status" for repeatedly calling in sick after exhausting his allotment of available sick days. Proof status requires employees to produce documentation of illness to support sick day requests. The employee submitted three notes from the same hospital covering five missed days during a six-week span. An OIG review of hospital records found documentation for only one of the visits. In an interview with the OIG, the employee stated all three notes were legitimate. The employee stated that a friend of his who worked in the hospital's emergency room allowed him to be seen ahead of other patients and ensured that no record was kept of the emergency room trips and that he was not billed for the visits. When asked by the OIG to provide the name of his friend on the hospital emergency room staff, the employee refused.

In an interview with the OIG, the hospital administrator responsible for emergency room staffing stated it was unlikely a worker could allow someone to bypass the waiting room as all patients are prioritized based on the severity of their ailments. The administrator also stated it was impossible that a physician would see a patient in the emergency room without a record of the visit being created. With the assistance of the hospital administrator, the OIG contacted two of the physicians whose signatures appeared on the notes. The doctor whose visit with the employee was documented in hospital records affirmed his signature on one note, however the second doctor denied writing the note ostensibly signed by him and provided a statement to that effect to the OIG. The physician's name on the third note did not correspond to any doctor at the hospital.

The employee previously served a three-day suspension for repeated unauthorized absences. The employee's personnel file also included entries for insubordination and inappropriate or unprofessional conduct.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should discharge the employee for falsification of doctor's notes used to excuse him from work.

The Department initiated disciplinary action, however the employee resigned his position with no reinstatement rights.

GENERAL INVESTIGATION 24

ALLEGATION

A private agency caseworker submitted fraudulent requests for Department funds allocated to assist clients in securing vital goods and services.

INVESTIGATION

The Department's Norman Fund assistance program is designed to aid families in need whose children could be taken in to custody based solely on factors arising from poverty. Norman funds are designated for use in securing or repairing housing, obtaining necessary food and clothing, or obtaining essential medical care. Requests are initiated by caseworkers who, after receiving their supervisors' signature, submit the proposals to the Department administrator in charge of the program. Following approval by the administrator, the requests are forwarded to a contracted private check processing company which produces the checks and holds them for the caseworker.

The Department's Norman Fund administrator reported an inordinate number of requests from a caseworker involving a single payee. The OIG obtained copies of all requests submitted by the private agency caseworker. All of the requests contained the caseworker's supervisor's forged signature. The supervisor and the director of child welfare reported that most of the agency's clients named in the requests had not been assigned to the caseworker and she would have had no reason to be involved with their cases. The director of child welfare informed the OIG she would meet with agency staff to review Norman Fund protocol and develop safeguards to prevent fraud.

The caseworker is currently employed by another private agency. The OIG has referred the information obtained in this investigation to the State Police and the State's Attorney's Office for possible criminal prosecution.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The OIG recommends the revocation of the caseworker's child welfare license.

The Department agrees.

2. This report should be shared with the private agency where the caseworker is current employed.

The Department agrees. The OIG shared the report.

3. To reduce fraud within the Norman Fund program, private agency requests for Norman Funds should come from an authorized designee in the business or administrative office of the agency. The authorized designee would be responsible for an internal control system of requests including:

- Work directly with the Norman Fund coordinator in obtaining Norman Funds requests by reviewing documents such as:
- **A copy of rental agreement**
- **A copy of the invoices for clothes/furniture**
- **Maintaining original receipts upon completion of purchases**

- Periodically test the reliability of the client information being provided by the caseworker and assure that the payee is a legitimate provider, by:
- **contacting landlords to verify available rentals**
- **ensuring that vouchers for clothing and furniture are being used only for the client.**

- **The authorized designee must give final approval before forwarding the necessary documents, together with the name of the caseworker authorized to pick up the check together with their phone number. The caseworker who subsequently picks up the check must show a driver's license, sign a receipt and provide a phone number. If the agency is not large enough to have a business office, the authorized designee should be an administrator of the agency. A file should be maintained on all clients receiving Norman Funds for a period of not less than 2 years.**

The Department is preparing to make a number of changes regarding Norman Cash Assistance. Per this recommendation, some of the following changes will be included in the next draft of the Norman manual:
- The Department has implemented a process by which private agency requests are made to special Purchase Of Service (POS) Norman liaisons who work for the Department. These POS Norman liaisons will be trained on how to identify possible fraudulent requests. When appropriate, the person approving the Norman Cash Assistance request will ask for invoices or other documents supporting the request.
- The Department will audit a portion of the requests approved to ensure that the client received the assistance requested.
- The person approving the request will make sure that the worker's name and phone number appear on Form 370-5
- When the cash assistance check is not mailed to the provider, the cash assistance provider will make sure that the person picking up the check will show proper identification and sign for the check.
- The POS Norman liaison will keep a copy of the request and the supporting materials for at least two years. The worker will also keep a copy of the request and the supporting materials in the case file.

GENERAL INVESTIGATION 25

ALLEGATION

Department employees involved in a program offering educational reimbursement in exchange for a minimum period of required service time to the Department may have voided their agreements by accepting early retirement.

INVESTIGATION

The Department's Social Work Education Program (SWEP) was designed to offer Department employees the opportunity to receive state funds to finance their pursuit of post-secondary degrees. In exchange, the employees agreed to continue working for the Department for a period of four years following the completion of the degree. The participation agreement entered into by these employees stipulates that if the employee were to discontinue their service or refuse a promotion during the four-year period, the employee would repay the total cost of their post-secondary education to the Department. Failure to do so would result in the Department taking legal action to recoup the funds and the employee accepting responsibility for any additional legal fees resulting from that action.

An OIG review of the Department's list of recent and impending retirees found individuals who, by discontinuing their employment, would fail to fulfill the four year requirement stipulated in their agreements. In light of the fiscal constraints faced by the state, the Department has an affirmative duty to recover funds to which it is entitled.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department's Office of Legal Services should provide the OIG with a list of retiring employees affected by SWEP participation agreements. The Department has an affirmative duty to act in accordance with Central Management Services policy and to recover funds to which it is entitled.

The Department agrees. The Office of Legal Services is in the process of identifying individuals who participated in SWEP in the past as well as current participants, and will develop a protocol to monitor the education and employment status of each individual. Once information is gathered and protocol is established, the Office of Legal Services will begin efforts to recover funds as appropriate.

GENERAL INVESTIGATION 26

ALLEGATION

During the course of a full investigation, the OIG discovered a private agency was financially insolvent. This financial insolvency compromised the agency's ability to provide services to foster children.

INVESTIGATION

During the course of an investigation involving Department wards, the OIG found the private agency had accumulated substantial debt. A field audit conducted by the Department showed the agency was indebted to the Department, the Internal Revenue Service, the Department of Employee Security and a lender bank. The agency was carrying a budget deficit equivalent to 35% of its annual revenue and had secured a bank loan in order to partially cover operating expenses. The agency had no sources of income other than government agencies and had not exhibited any fund raising ability. At the conclusion of the time period covered by the audit, the agency had $1,270 available to meet monthly payroll expenses of $100,000.

The Department report regarding the audit was not completed until 19 months after the period under review. The audit report focused on money owed by the agency to the Department rather than the agency's dire financial condition and its impact on the ability to provide effective services. There was no indication the information obtained through the audit was considered in terms of future contracting decisions.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should immediately consider the private agency's current financial condition and ability to provide foster care services before contracting with the agency in fiscal year 2004.

The Department has evaluated the private agency's contract and services that are currently provided. Efforts have begun to transfer all cases from the agency with the intent to cease contracting with the agency in the early part of 2004.

GENERAL INVESTIGATION 27

ALLEGATION

The closure of a private child welfare agency necessitated the transfer of a large number of cases. Inherent problems with the Department's procedure for case assignment resulted in the cases of foster children residing in the same home to be assigned to two different agencies.

INVESTIGATION

During an investigation involving Department wards, the OIG found that responsibility for a foster home, caring for two foster children and a foster grandchild, was divided between two private agencies. The split in licensing and child welfare services occurred after another private agency permanently closed, necessitating the immediate transfer of over 300 children's cases. When the Department reassigned the cases, the foster home license and the foster grandchild were assigned to one private agency while the two foster children were assigned to the other.

The Department's present rotation-driven case assignment system undermines the authority and accountability of the licensing agency; a fiduciary responsibility on which the public relies. The Department cannot continue to split the licensed foster family and their foster children among agencies.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department's case assignment unit should be directed to immediately cease the practice of splitting agency responsibility and to assign full responsibility for the foster home license and the foster children in that home to the same agency.

In February 2003, notice was sent to executive staff that no foster homes servicing home of relative or traditional cases were to be split between agencies when case reassignment occurs. In addition, if a split is necessary due to specialized programming, Agency Performance Team monitoring must ensure the transfer follows Department policy. This notice will be reiterated to staff by February 1, 2004.

GENERAL INVESTIGATION 28

ALLEGATION

The Department compromised the safety and best interests of children by failing to enforce Department rules regarding health standards for unlicensed relative foster parents.

INVESTIGATION

In 2000, the Department, acting in response to previous OIG recommendations, began requiring prospective foster parents to have their physician complete a detailed medical reporting form affirming each member of the household and other child care providers were free of communicable diseases or other significant physical or mental health problems. In 2002, the Department issued an amended application available only to unlicensed relative caregivers seeking licensure. This application required only a self-report of the medical conditions of household members and included no provision for corroboration by a medical professional.

Although the intention of the measure may have been to accelerate the process of granting licenses to unlicensed relative caregivers, thereby entitling the Department to Title IV-E reimbursement funds under state law, the potential risk posed to children by eliminating the requirement for medical examination outweighs any perceived benefits. A number of OIG investigations in recent years have illustrated the dangers inherent to allowing individuals with significant physical or mental health problems to care for wards. This has been particularly apparent in regards to older caregivers who comprise a significant number of unlicensed relative caregivers. The health of members of a foster family has been identified as a critical variable affecting both direct care of children and the overall status of living environment. Allowing any prospective foster parents to forgo assurance of a key element to providing a stable home places Department wards at unnecessary risk.

Soon after this OIG investigation, the Department rescinded the amended license application for relative caregivers.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should require that all current and future relative foster care license applicants submit the physician certified medical reporting form issued in August 2000 rather than the self-report form.

The Department amended the application process to require that all relative foster care applicants provide a physician certified medical reporting form. All relative homes that were licensed prior to this requirement will submit the appropriate form as a condition of the renewal of their license.

2. The Department should suspend claims for Title IV-E reimbursement for the 20 relative homes licensed since August 2002 under the new application that allows certified medical self-reports.

The Department's implementation of the previous recommendation has addressed this issue.

GENERAL INVESTIGATION 29

ALLEGATION

Vital personal information of Department employees is freely available to all staff through the Child/Youth-Centered Information System (CYCIS) database.

INVESTIGATION

The Department's current configuration of the CYCIS database allows for unrestricted access to the home addresses, phone numbers, and social security numbers of all Department employees. As this database is readily available to all employees, the absence of any checks or filters to prevent the dissemination of essential personal information raises serious privacy concerns. The personal information of Department employees should be regarded as confidential and its release restricted by the Office of Employee Services.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The current CYCIS system should restrict access to personal employee information (social security number and home address) on the provider screens or remove such information entirely.

The Department agrees to explore the feasibility of restricting access to employees' personal information.

2. The Department should ensure that the design of the new SACWIS system ensures staff privacy for personal information.

This recommendation will be shared with SACWIS designers with instructions that it be implemented.

GENERAL INVESTIGATION 30

ALLEGATION

At the request of the Director, the OIG investigated the status of wards currently designated by the Department as "missing" and assisted the Department in attempting to locate the children. This investigation identified several aspects of Department policy and procedure in need of revision.

INVESTIGATION

The OIG initiated a review of Department cases involving wards whose whereabouts are unknown as well as Department procedures for notifying law enforcement and locating missing children. The OIG found that while the Department had made a concerted effort to develop a uniform system for reporting runaway wards, the effort was concentrated on Department caseworkers and largely overlooked private foster care and shelter care agencies responsible for providing services to the majority of wards. The OIG also found the Department had removed the "missing" designation from wards whose whereabouts remained unknown but who had made some phone contact with their workers or former caregivers. Children on run frequently contact family, friends or trusted individuals. The omission of children who had made contact without returning created an inaccurate representation of the number of Department wards actually missing.

Runaway children are an especially vulnerable population. When it becomes apparent a ward is missing it is vital that police are contacted immediately. In a number of cases, missing child reports had never been filed with local police. In some cases, wards' caseworkers mistakenly believed filing for a child protection warrant automatically created a missing child report. Currently, Department Rule 329 could be misunderstood to require a foster parent to first notify a ward's caseworker of a child's absence prior to calling police. Because of time constraints faced by private agencies and in order to expedite the process in the interest of child safety, the OIG provided direct assistance in completing police reports for these wards and attempting to locate them.

The Department identified 166 wards under the age of 18 as missing. With assistance from two Department staff members assigned by the Director, OIG investigators located 112 (68%) of the missing children.

A number of the children reported as missing were older wards believed to have left their placements for a variety of reasons. Some sought to reunite with biological parents while others, particularly pregnant or parenting female wards, moved in with their paramours and/or their paramours' families. When these children are located, it is necessary to attempt to engage the wards and their families in services through utilization of family conferences and, when appropriate, Parenting Assessment Team (PAT) evaluations. In instances where wards are found to be living with biological parents with histories of substance abuse or mental illness, Intact Family Services can provide a vehicle for determining the viability of these arrangements and assisting during the transition to a new living situation.

Several missing wards were located within the juvenile detention system. By developing a more streamlined relationship with law enforcement agencies, child welfare professionals can improve the likelihood of more quickly identifying and locating missing Department wards.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. A large number of missing pregnant or parenting youths had been placed in Chicago by a private agency based outside town. In order to develop a better working relationship with the Chicago Police Department and other agencies needed to assist these youths, the private agency should open a satellite run unit in Chicago.

The Department agrees that there is a need for a better working relationship with the Chicago Police Department and other agencies in the area. Because of the many changes in the programs for older youth, a

comprehensive solution to this issue will be developed by March 1, 2004.

2. In cases where the older youth desire to return to a parent who has had a history of substance abuse, the Department should adapt and pilot the specialized substance abuse services of the Intact Family Recovery project for Family Reunification Services. The use of extended visits can allow opportunities for applied problem-solving with the support of the IFR teams. In cases where the involved youth is a parent, the IFR team can assist in early childhood services and well-baby checks.
3. In cases that involve a parent with prior mental health history, a Parenting Assessment Team evaluation focusing on return of the older youth can provide a guided plan for services and extended visits that lowers risk while reunification occurs.

4. In cases where older pregnant or parenting youth are found living with boyfriends or the father of their child or with the child's paternal family the Department must make an effort to involve the boyfriends, the fathers and the extended paternal family in a family conference for the future safety of the young family.

5. Some children on the lists of missing children are in reality living back with their parents. These children are listed as missing, in an unauthorized placement with self, in an unauthorized placement with the parent, or as living with the parent. All such children should be shown with a living arrangement as HMP (home of parent). The unapproved nature of the placement can then be explored with family conferencing.

6. Children with Child Protection Warrants with whom the Department has no legal relationship should be entered into the CYCIS database with a living arrangement category that reflects the reality of their situation. If a list of such children could be generated from CYCIS, the Department could then be looking for those children as well as those with whom it has a legal relationship. The child in this category is not technically a missing child nor an abducted child, but is a child that the Department and the Court believed was at risk. A Child Protection Warrant would not have been issued unless the Court found probable cause.

In response to the five previous recommendations, the Department is currently in the process of changing policies as they relate to the 5,200 youths over 18 years of age the Department has a relationship with. This will be completed by June 1, 2004. These recommendations will be part of those changes.

7. The Department should revise procedures for missing and run away children (Procedure 329). To ensure the fastest possible response time from law enforcement and child welfare professionals, the OIG recommends that procedures require *caregivers to notify the police* in instances when children are missing or foul play is suspected. Caregivers are then required to notify caseworkers or the DCFS Runaway Hotline. Caseworkers are required to provide the police with follow-up information, notify the National Center for Missing and Exploited Children, notify the parent(s) or guardian of the child, the child's Guardian ad litem, Juvenile Court, and file an Unusual Incident Report. The caseworker is also required to make attempts to locate the child immediately and on a regular basis thereafter.

Since a child's vulnerability varies by age and capacity, the OIG recommends alternative actions based on the circumstances of the disappearance, the child's age, and the child's vulnerability. The highest level of response is warranted for a child:

- **of any age who is *abducted*, or**
- **if there is a *suspicion of foul play*, or**
- **if the child is *vulnerable*, or**
- **if the child is *under 14 years* of age.**

The police should also be notified if a child between 14 and 18 years of age, has not returned home

within two hours after curfew. If a child over 18 years old is missing, but is not vulnerable and there is no suspicion of foul play, the caregiver should contact the caseworker and the caseworker should make attempts to locate the child immediately and regularly thereafter.

When a runaway child is found, either by police or others, the OIG recommends alternative actions based on the child's age, frequency of run behavior, and duration of time between run episodes. Depending on the child's previous runaway behavior and other risk factors, child welfare staff should place the child, if possible, with a caregiver the child trusts and who is willing to cooperate with a family conference. The caseworker should then coordinate the appropriate team to arrange for the necessary services, including family conference, assessments, and transportation to the child's former school. The caseworker is responsible for notifying the child's parents, guardians, previous caretakers, police, and court personnel of the child's return.

The Department agrees. Procedures 329, Missing, Run Away, and Abducted Children have been revised, incorporating the above recommendations.

GENERAL INVESTIGATION 31

ALLEGATION A 20 year-old parenting Department ward discontinued contact with the private agency handling her case. The private agency failed to take adequate measures to locate her and ensure the well being of her children. Two years earlier, the ward's three month-old son died of asphyxiation when she rolled over on him while they were sleeping in the same bed.

INVESTIGATION The mother was removed from her home at age 12 and placed in the custody of a licensed foster parent along with her four siblings. Four years later, the mother had her first child, a girl, and her case was transferred to a pregnant and parenting teen program. One year after the transfer, the mother informed her caseworker she was pregnant again by the same father as her first child. A few days after the second baby, a boy, was born, the mother's foster parent passed away. Because the mother was 18 at the time she was allowed to reside in an approved, self-selected placement. The mother selected the home of her foster mother's sister. Although a criminal background check of the foster mother's sister found the woman had an extensive history of arrests for assault, robbery and weapons violations, the mother was placed in the home. The OIG obtained the underlying documents for the arrests and found that in one instance the woman was alleged to have shot her boyfriend during a domestic dispute, however the man refused to press charges. According to the police arrest report the woman had also shot her boyfriend on a previous occasion.

The rollover death occurred in the home of the children's paternal grandparents three months after the second child was born. The grandmother stated she returned home to find the mother and her two children sleeping in the same bed when she noticed the boy was not breathing and blood was coming from his nose. The mother stated she slept with the children as a result of her fears regarding crib death. The medical examiner determined the death to be accidental but noted the baby's height and weight were less than the third percentile for his age. The two year-old girl was placed in her father's custody. Both parents were offered grief counseling by the Department but declined to participate.

Four months after the baby's death the mother wanted to return to her previous foster home. Although the late foster mother's husband agreed to the placement, it was not completed and the girl went to live with his brother. Eleven months later, the mother gave birth to her third child, a girl, by the same father. The mother's caseworker did not see the mother and child until three weeks after the baby's birth when she conducted a home visit. During the visit, the caseworker learned the mother was sleeping in the same bed as her two small children. The caseworker's notes show the acquisition of a separate bed was discussed and a check was provided for its purchase, however there is no indication another bed was ever obtained. The caseworker informed the mother a nurse from the private agency would visit the home to complete safety training. On the scheduled day of the training the mother was not home and after the nurse had to cancel a second appointment, a phone consultation was conducted instead. During the conference call, the mother, the nurse, the caseworker and the mother's caretaker discussed safety issues, however the nurse never performed a follow-up visit in the home to ensure the mother had internalized the information.

One month after the conference call, the mother's caretaker told the caseworker he was being treated for prostate cancer and could not continue to house the mother and her two children. When the caseworker informed the mother she would be placed in a shelter unless she identified another placement, the mother requested her case be closed. The mother then moved into an apartment in a building owned by her caretaker, unbeknownst to the caseworker. By the time the caseworker learned of the apartment, the mother had moved and the new address was unknown. The caseworker had not seen the mother or her children for five months at the time the mother was reported missing. The case was transferred to another worker who obtained an address for the mother but was unable to identify a corresponding building. Three months after this information was obtained, two workers from the agency's "run unit" visited the address. Although the

number was incorrect, the workers found the names of the mother and father on the mailbox of a home with an address two digits higher than the one provided. The workers reported the appearance of people in the home, but no one would answer the door. The second caseworker obtained a cell phone number from the children's pediatrician and contacted the mother, however the mother refused to provide her address and restated her desire that the case be closed. The OIG contacted the pediatrician to obtain the children's medical records and attempt to locate the mother. A review of the medical records found the mother had been fairly consistent in scheduling and attending appointments. The pediatrician informed the OIG he had previously honored a request by the caseworker to have the mother contact the private agency prior to the mother's next appointment, but when he did the caseworker informed him that agency staff did not need to meet with the mother because her case was being closed. The pediatrician stated he called the agency when the mother arrived for the visit and agency staff informed the mother of the pending case closure.

In another attempt to locate the family, the OIG contacted the mother's former caretaker. The former caretaker expressed his belief the mother and father had recently been married. The OIG obtained information from the county clerk's office confirming the marriage and found the couple had been wed for three months before her contact with the private agency ceased. At no point did the caseworker or staff from the private agency attempt to contact the father or his family despite his continued presence in the mother's life. A family conference would have been an effective means of identifying all concerned, involved individuals and assuring the collection of accurate, relevant information. By utilizing the resources of a family conference following the boy's death, the private agency could have addressed health and safety issues for the mother and children as well as to engage the father and his family in the services available to them.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Family conferences should be convened in cases where a parenting ward has a steady relationship with the infant's father and his family. The conference can be used to share home and safety information with the father and his extended family.

Rules and Procedures were revised per this recommendation. Notice will be sent to staff informing them of the change in policy by February 1, 2004.

GENERAL INVESTIGATION 32

ALLEGATION

The OIG reviewed cases in which infants whose families were involved with the Department died of sleep-related deaths.

INVESTIGATION

The OIG reviewed 17 sleep-related death cases from the 2002 and 2003 fiscal years in order to determine how the Department could improve infant sleep safety among the client population. The OIG conducted interviews with caseworkers and supervisors involved in these cases, reviewed Department policy and training materials and examined leading scientific research in the field of infant sleep safety.

Although the exact cause of SIDS is unknown, the American Academy of Pediatrics (AAP) has identified a number of risk factors that increase the likelihood of SIDS among the most vulnerable population, infants between the ages of 27 days and 11 months. While some risk factors such as premature birth and/or low birth weight, the parent's age and the infant's race or gender cannot be controlled, several other factors can be addressed to create a safer environment and reduce the likelihood of SIDS deaths. These modifiable risk factors include infants sleeping in a prone or "face down" position, sleeping on soft surfaces or with soft toys and bedding, increased body temperature from excessive clothing or blanketing, and sharing sleeping spaces with adults, particularly those under the influence of drugs or alcohol.

Since the AAP initiated the "Back to Sleep" program in 1994, encouraging parents to place infants in a supine position for sleeping, the national rate of SIDS deaths has decreased dramatically. However, SIDS remains the leading cause of death among post-natal infants. Studies have found minority infants to be at disproportionate risk and environmental factors such as poverty, parental inexperience and lack of a social support system only serve to escalate the potential danger to infants. As these factors relate directly to a majority of families serviced by the Department, it demonstrates the vital need for Department workers involved with families caring for infants to be knowledgeable about the issue and to have resources at their disposal to assist in reducing or eliminating these risk factors from clients homes.

An OIG survey of Department caseworkers found a great deal of unfamiliarity with specific means for minimizing the risk of sleep-related deaths and a dearth of information and guidance provided by the Department. Only half of the workers questioned by the OIG stated they had received SIDS prevention training. Currently, Best Practice Fundamentals Training does not include modules on infant sleep safety or the assessment of environmental risks, despite previous recommendations by the Illinois Child Death Review Teams. Although many of the workers surveyed demonstrated basic knowledge of SIDS, many lacked familiarity with the key risk factors identified by the AAP. In addition, caseworkers expressed concern regarding their ability to devote additional time to families given the constraints imposed by their already burgeoning caseloads. Workers also stated a reluctance to focus on issues outside a family's initial reason for involvement with the Department and fear of increased liability if a SIDS death were to occur after specific actions were taken to address the issue. Despite these impediments, it is clearly the Department's responsibility to ensure the safety and welfare of all children under its care. In order to do so, the Department must provide workers with instructional training, clear procedural guidelines and access to educational materials and necessary resources to help establish safer sleeping environments for infants.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should reduce environmental risks to children by:

a) amending its contract program plans for private agency intact family programs to require the use of the home safety checklist and;

b) incorporating the home safety checklist into the Child Endangerment and Risk Assessment Protocol (CERAP) process. In child protection investigations involving families with infants, investigators need to inspect the home to ensure that each infant has its own crib or bassinet with a firm mattress. An infant without a crib or bassinet with a firm mattress indicates an unsafe factor on the CERAP that must be addressed by educating the family about sleep safety. Also, child protection investigators should help families obtain a crib. Any time an infant is placed in a home via a CERAP safety plan, the child protection investigator must ensure there is a crib in the home and educate the caregivers about infant sleep safety.

The assurance of adequate sleeping arrangements will be made a part of the CERAP. The home safety checklist has been sent to the Office of Child and Family Policy to be incorporated into the Department's Rules and Procedures.

2. The Department and private agencies should make portable cribs (e.g., Pack and Plays, estimated cost $59-79) or similar products approved by the Consumer Product Safety Commission available to families on an emergency basis.

The Department will explore at a regional level how to obtain cribs. This will be considered for the fiscal year 2005 budget.

3. The Department should initiate a safety campaign to address home safety, including sleep safety. This report, Dr. Kalelkar's videotape, "The Hazards and Risk Factors of Co-Sleeping and Bed Sharing," public service safety videos, and other free printed materials should be made available to workers to help them understand the importance of reducing environmental risks.

The Department will produce "Zero to One" packets that will include important information on safe sleeping for all families that are involved with the Department. In addition, the Department will arrange for a visit from a public health nurse for all families with children aged zero to one year of age.

GENERAL INVESTIGATION 33

ALLEGATION Caseworkers involved with five Department wards enrolled in an alternative school for children with emotional and behavioral disabilities did not participate in planning and assessment meetings for an entire school year.

INVESTIGATION All five wards attended the alternative school because they presented moderate to severe learning, behavioral or developmental disabilities. The wards had been identified as eligible for special educational services as the result of Multidisciplinary Conferences (MDC). These conferences are required to be held once every three years in order to determine a course of action for determining a ward's educational plan. The initial MDC, conducted upon a ward's entrance into Department custody, results in the formulation of an Individualized Educational Program (IEP) which is revised annually. The IEP establishes the ward's educational needs and requirements for the upcoming school year. Of the five wards, four resided in group homes while the fifth lived at home with his mother. The fifth child's case with the Department was closed prior to the complaint being lodged with the OIG.

Department rules include a provision calling for an educational surrogate parent to engage in these proceedings on behalf of foster children. In the case of wards residing in group homes, the state Board of Education appoints volunteers to serve in this capacity in accordance with the Individuals with Disabilities Education Act (IDEA). An OIG review of the four wards living in group homes found that only two of their educational surrogate parents were invited to IEP meetings and none of the four attended. The State Board of Education is only required to inform educational surrogate parents of IEP meetings. There is no requirement that involved child welfare workers be notified of upcoming IEPs. Only one of the ward's caseworkers attended an IEP during the school year in question. That worker was notified of the meeting by the ward's school. Department rules require caseworkers to communicate with school personnel once a month and establish in-person contact once per quarter, however the OIG found that staff from the wards respective group homes had assumed much of the responsibility for fulfilling these requirements. Although group home staff have direct, daily involvement with wards and are more likely to be aware of educational developments, caseworkers maintain primary responsibility for servicing cases and must assume a primary role in ensuring that the educational needs of wards are met.

Department policy also provides for periodic Administrative Case Reviews (ACR) to examine a ward's current situation. An OIG review of ACRs conducted for the four wards found that while the ACR reviewers were aware the children's caseworkers and educational surrogate parents were not attending IEP meetings, the reviewers did not consider the potential impact this lack of involvement might have on the children's educational interests. ACR reviewers involved with these cases who spoke with the OIG related differing views on the scope of their authority to compel caseworkers to participate in MDC or IEP meetings.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Department Procedure 314 Educational Services should be required clear that for children placed in group homes or residential facilities, the Department caseworker shall:
a) communicate at least quarterly with the child's school, including at least one in-person visit annually;
b) read the child's Individualized Education Program (IEP) plan to identify the child's learning issues;
c) seek meeting dates of MDC/IEP conferences and attend the MDC/IEP conferences; and
d) notify the state board of education of educational surrogate parents that are unavailable or uncooperative and/or request that a new surrogate parent be appointed.

Rule 314 has been under revision and is due to be completed by February 1, 2004. These recommendations will be incorporated in the revisions.

2. The Department's Division of Education and Transition Services staff should provide training on workers' education-related responsibilities.

The Department agrees. Upon completion of the revisions to Rule 314, training will be provided.

3. This report should be shared with the Inspector General of the State Board of Education.

The Department is currently meeting with the State Board of Education to refine and streamline procedures pertaining to educational services for wards. A decision on whether additional notification is necessary will be made at the conclusion of these meetings.

GENERAL INVESTIGATION 34

ALLEGATION

The OIG examined the cases of four terminally ill Department wards in order to review pediatric hospice care.

INVESTIGATION

The OIG initiated this investigation to assess the Department's ability to provide pediatric palliative or hospice care to terminally ill Department wards. Palliative care is designed to assist in the treatment of children who have been diagnosed with a serious, life-threatening illness. Palliative care works to enhance the quality of life of both the child and their family through comprehensive services that address their social, psychological and spiritual needs. Palliative care is intended to provide for children who overcome their illnesses as well as those who may not survive. Hospice care, of which palliative care is an integral component, is traditionally available to patients in the last six months of life. When a child is referred to a hospice program, there is an understanding that the child will not survive their medical condition. Curative and life-prolonging treatments are discontinued. In this model of care, it is possible to continue only those treatments that relieve symptoms of the illness or reduce pain. Within hospice care, bereavement support and services are offered prior to, during, and after the death of the child.

Currently, there is no Department protocol to instruct medical and case management of terminally ill children. The wards involved in the four cases reviewed by the OIG resided in different living arrangements prior to their deaths. A 13 year-old boy with a rare enzyme disorder was cared for by his foster mother at home. A seven year-old male cancer patient was hospitalized and received services from a hospice with a pediatric specialty. A 15 year-old girl with cerebral palsy was provided with hospice care in her adoptive home. A three year-old girl born with a congenital HIV infection received hospice care while placed in a specialized pediatric AIDS facility. All children in state care with known incurable diseases must be afforded the opportunity for enhanced quality of life that is symptom and pain controlled.

In August 2000, the American Academy of Pediatrics issued a policy statement calling for palliative care services to become much more widely available to children beginning when they are diagnosed with a condition that could kill before they reach adulthood. A recent study conducted by the Children's International Project on Palliative/Hospice Services found only 10% of dying children nationwide receive hospice services. The less predictable nature of adult diseases in children, the potential social stigma of "giving up" on a child and the shortage of hospice providers equipped to serve pediatric patients are barriers to greater utilization of these services for terminally ill children.

Hospice care is greatly beneficial to terminally ill children and their families or guardians because it provides comfort and support during a period of dramatic and tragic transition. Hospice care helps provide a more comfortable, stable environment to maximize the quality of the family's remaining time together while allowing all involved to address issues of grief and bereavement. Hospice care has been shown to be a much more cost-effective way of providing valuable care to terminally ill patients than extended hospital stays. The greatly reduced cost of care can ease the financial burden on emotionally overextended families. In addition, hospice services do not end when the patient dies. Families often receive services to help them adjust to the loss and agencies often provide individual counseling and group support for families, including siblings.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department Guardian, together with foster children living with life threatening illnesses and their foster parents, and if appropriate, biological parents, should develop an individual care plan that considers the age appropriate wishes of the child, the spiritual, physical and emotional needs of the child and his/her caregivers, and provides for appropriate child focused palliative and/or

hospice care.

The Department agrees. The Guardian's Office considers palliative care as an option for treatment.

2. The OIG previously recommended the Chief of Nursing Services be transferred and placed under the supervision of the Department Guardian's Office to assist with medically complex cases. This position should be responsible for ensuring that dying children in state care are referred for palliative and/or hospice services, as well as coordination and monitoring of the child's end of life care.

There will be a review and redesign of the reporting and structure of the nurses by March 1, 2004.

3. Where permanency is being achieved for a child with a life threatening illness, the adoption or guardianship subsidy must reflect the individual care plan.

The Department agrees.

4. The Department Division of Health Policy, in conjunction with HealthWorks of Illinois should develop and distribute a directory of pediatric palliative and hospice services. The directory along with the American Academy of Pediatrics policy statement on palliative care for children should be disseminated to HealthWorks physicians, the South Side Health Consortium and HealthWorks lead agents throughout the state.

The Division of Health Policy will disseminate this information by February 1, 2004.

GENERAL INVESTIGATION 35

ALLEGATION

The OIG investigated pharmacological approaches to treating aggression in children, particularly the use of "beta-blockers," hormone inhibitors found in many widely prescribed drugs.

INVESTIGATION

Aggression in children and adolescents becomes a serious problem when it is used as a means of coercion or when the severity or intensity of episodes extends beyond the normal limits of a caretaker's control. It is important for caregivers to respond quickly and effectively to prevent such behaviors from becoming reinforced or ingrained. While the true causes of pediatric aggression are unknown, a variety of biological, cognitive and neuropsychological factors can contribute to promote aggressive behavior. Family history, sex and age can serve as predictors for some children while low intellectual functioning, Attention Deficit Disorder (ADD) and poor social development are more prevalent causes of aggression in others. Neuropsychiatric factors, specifically abnormal brain function, are thought to play a role in the development of aggression and may be inhibited or exacerbated by other biological functions.

Norepinephrine is a hormone secreted by various systems in the body which causes the constriction of blood vessels. Researchers have drawn a correlation between this process and the expression of aggressive behavior. Some studies have shown that when the hormone is blocked through the use of beta-adrenergic antagonists (beta-blockers), some aggressive behaviors become inhibited. The absence of a precise understanding of the biology of the brain and a lack of research into the efficacy and potential dangers of using these drugs with children has limited available knowledge. However the use of multiple psychotropic medications to treat aggression in children is common. Most current thought concludes the use of beta-blockers lacks the specificity necessary to treat aggression and results in unfocused clinical intervention. Furthermore, such treatment can produce an increased risk of serious side effects.

Department wards, the majority of whom have experienced tumultuous personal lives and possess many of the apparent factors for aggressive behavior, are jeopardized by unsuccessful treatment of aggression. These wards may be further compromised if psychotropic drugs prescribed to them are taken intermittently or in conjunction with other prescribed or illicit drugs. Furthermore, the use of beta-blockers can exacerbate existing medical conditions such as asthma and diabetes. Wards engaged in a psychotropic drug program must be made fully aware of the consequences involved with non-compliance. These wards should also be closely monitored to determine the efficacy of such drugs and educated to utilize tracking tools such as a mood diary to record potential symptoms of aggressive behavior.

A more uniform and comprehensive approach is necessary to effectively manage wards with identified behavioral problems. Children who have required two psychiatric hospitalizations in one year or three hospitalizations within a two-year period should be provided with intensive, focused case management. For other wards whose behavior has not risen to that level of severity, the implementation of non-medical therapeutic options and consultation with caregivers and teachers should be explored. When psychotropic drugs are prescribed, their use should be tightly controlled and monitored. Frequently these drugs are administered to wards on a "trial and error" basis, a practice that can result in further emotional disruption and unforeseen physical problems for the ward. Any side effects of psychotropic drugs should be identified and recorded both to develop a clearer understanding of a particular ward's needs as well as to assist in the formulation of the best possible course of treatment. Diligent observation would also serve to further awareness of the properties of these medicines.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. In 2001, the Inspector General recommended the Department require the use of developmentally appropriate behavioral monitoring and tracking for any child on psychotropic medications by using reporting forms similar to those used by the Illinois State Board of Education. The Guardian's Authorizing Agents should require and gather vital information from the contracting agencies prior to authorizing the approval of medications for the children in their programs. This information should include, but not be limited to: baseline weight, weight gain/loss, blood pressure, cardiac measures, and dyskinesia. Baseline information pertaining to the targeted behaviors and programming used to target the behaviors should also be obtained to ensure that medication is not used in lieu of programming.

The Inspector General also recommended that the Department require that children and adolescents on psychotropic medication be taught how to use a developmentally appropriate daily mood diary to encourage self-monitoring of their own behaviors. The tool must be adapted for the developmental level of the child. The Inspector General reiterates these recommendations.

The Department is in the process of identifying wards who are currently on psychotropic medications. Once these wards have been identified, a tracking system will be developed to monitor them.

2. The tools developed pursuant to the recommendation above should be forwarded to a multi-disciplinary panel including the guardian, psychiatrists, psychologists, a pharmacologist, adolescent health experts, ethicists and selected independent examiners. This panel should examine the present population of high-risk wards, many of whom include children and youth receiving beta-blockers and multiple psychotropic medications, to recommend placement and treatment options.

The Department will identify and examine the present population of high-risk wards through Integrated Assessment.

3. The Department should include the recording of side effects in the Medication Administration Log (Form CFS 534).

The Department will consider revising the medication administration log form to include significant side effects the ward receiving the medication may be experiencing.

GENERAL INVESTIGATION 36

ALLEGATION

The OIG reviewed the organization and utilization of the Department's nursing staff.

INVESTIGATION

General medical consultation on child welfare cases is a necessary and important responsibility for Department nurses. Under the current organizational structure, however, they impart expert medical advice without direct supervision by qualified health care professionals, such as nurse managers/supervisors or medical doctors. The OIG maintains that lack of clarity regarding nurses' job responsibilities and lack of supervision can lead to dangerous conditions for Department wards. Multiple OIG investigations have shown that Department nurses sometimes provided medical advice that was either untruthful or incomplete. In one case, Department staff accepted a nurse's statements about a family as her professional and informed medical judgment. Her statements later were found to be biased and hostile toward the family. Nevertheless, acceptance of these statements prevented the parents from obtaining necessary services for their child. The nurse was never held accountable for these statements, even after they were found to be untrue. In another case, a nurse's care plan for a medically complex child never specified who was responsible for carrying out necessary medical procedures. Further investigation found that she gave this advice without examining the infant or reviewing the infant's case record.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Department Child Welfare Nurse Specialists should be assigned to the Division of Child Protection. Nurses then could utilize their medical background, and obtain necessary supervision by the child protection team. Also, Department Nurses should work with the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC), in order to conduct scene investigations, collect medical records, and conduct collateral interviews in cases involving children with head injuries. Finally, the Chief of Nursing Services should be transferred to and placed under the supervision of the Department's Guardian's Office to assist in medically complex cases.

There will be a review and redesign of the reporting and structure of the nurses by March 1, 2004.

COOPERATION WITH LAW ENFORCEMENT AGENCIES

In furtherance of our statute, the OIG frequently works closely with law enforcement entities. The following cases are illustrative of that cooperation.

Case #1
A teacher was indicated for sexual molestation of his ten year-old daughter. The child protection worker never inquired as to the father's employment and, as a result, the school was never notified of the indicated finding. The father informed the school that the report against him had been unfounded and he continued his employment as a teacher. The local police department had not taken any action against the father. OIG investigators met with the Deputy Chief of Detectives of the local police department to discuss the case. Based on the information supplied by the OIG, the police revisited the case and arrested the father. He pled guilty to one count of Aggravated Criminal Sexual Abuse and was given 30 months of probation. The local school board terminated him as a teacher and the State Board of Education withdrew his teaching certificate.

Case #2
A caseworker took a five year-old boy who was in placement in a traditional foster home to visit his relatives out of state. The worker noticed that the boy had difficulty manipulating his fingers and marks on his wrists and took the boy for a medical exam when they arrived in the visiting state. The boy explained that he had been tied up by his foster father and hung on a door by his t-shirt, an explanation the doctor determined was consistent with his injuries. The worker called the abuse and neglect hotline and notified the local police in the city where the foster father lived. The boy remained with the relatives out of state and was recently adopted by that family. The local police department requested assistance from the OIG in securing the boy's medical records and preparing a case against the foster father. The criminal case on the foster father remains open at this time.

Case #3
During a child protection investigation, the OIG was contacted for technical assistance with an out of state criminal history on a registered sex offender who was living in a home with three young girls. A criminal history evaluation conducted by the OIG revealed that the man had a substantial criminal history in Illinois and Tennessee, including a conviction for sexual battery against a 15 year-old girl. There were also outstanding warrants in the state of Tennessee. The OIG notified Tennessee authorities of the man's whereabouts but they declined to extradite. Because he was on parole in Illinois, the OIG notified the parole supervisor that he was living in a home and acting as caretaker to three young girls, one of whom was the age of his victim in Tennessee. The parole supervisor dispatched an officer to the home and notified the parolee that he must cease all contact with the girls and that future contact would be considered a parole violation. The man was placed on electronic monitoring. Also, the OIG noted that the law enforcement database only listed the man as a sexual offender, not a *child* sex offender. After notification by the OIG, the man is now listed a child sex offender.

Case #4
A group home employee allegedly impregnated a 15 year-old Department ward. By the time the OIG was notified, the employee had resigned from the group home and obtained employment with the city of Chicago. The OIG contacted law enforcement and the former employee was arrested and charged with criminal sexual assault. His criminal case is pending.

Case #5
The OIG reported a 72 year-old minister to the DCFS hotline for sexual abuse involving a 14 year-old ward. The minister was indicated for sexual abuse. The OIG contacted law enforcement on several

occasions to request criminal prosecution. The man was arrested and charged with kidnapping, aggravated criminal sexual assault, aggravated criminal sexual abuse, and unlawful restraint and released on bail. The OIG also informed law enforcement that the minister carries a police badge and regularly impersonates a police officer. On a court date regarding the above charges, law enforcement set up surveillance at the criminal courts building and watched as the minister arrived for his court appearance, produced his badge, and told the sheriff's deputies that he was an active police officer on duty. He was arrested and charged with impersonation of a police officer.

Case #6

In the process of investigating a case in which foster parents were alleged to have sexually and physically abused their foster and adoptive children, the OIG noted that the brother of one of the foster parents was a registered sexual offender and that he was living in the foster home at the time that the sexual abuse by the foster father was disclosed. The maternal uncle stated that he was living in the home to help remodel the house. According to the Licensing Study, the foster mother met the foster father through her brother. The OIG conducted a criminal background check of the maternal uncle and learned that in 1992, he was convicted of felony burglary. In 1994, he was charged with 1st degree sexual assault of a child, which, in 1995, was pled down to 4th degree sexual assault. In August 1995, he was convicted of possession of a firearm by a felon. In 2001, he was arrested for domestic abuse and disorderly conduct. On October 2, 2002, he was arrested in another state for 3rd degree sexual assault. The OIG contacted local law enforcement to alert them to the presence of another possible perpetrator at the home. The foster father was convicted of Predatory Criminal Sexual Assault to Child. He was convicted on three counts and sentenced to serve three consecutive 20 year sentences.

Case #7

A private agency caseworker was suspected of embezzling Department funds allocated to assist clients in securing housing, food, and essential medical care. A preliminary investigation by the OIG revealed that 12 of the 19 checks issued as a result of requests submitted by the caseworker were drafted to the caseworker's husband and other acquaintances. The 12 clients listed as the beneficiaries of the fund assistance had not requested the funds and had no knowledge that their names had been used to obtain money from the Department. The OIG referred the case to the Illinois State Police and to the Office of the State's Attorney. Investigations by both law enforcement agencies are pending.

Case #8

A preliminary investigation by the OIG revealed a file on a Department computer technician's work computer that contained sexually explicit internet chat room conversations with females identifying themselves as under age 18. The OIG referred the employee to the Illinois State Police (ISP) for investigation of solicitation of minors over the internet. While the state police investigation confirmed that at least one of the participants in the chat room was a female under the age of 18 and the Department employee had identified himself to her as also being under 18, the state police did not charge the employee because he did not arrange to meet with any of the minors. After the ISP completed their investigation and the State's Attorney decided not to prosecute the worker, the OIG conducted a full administrative investigation. The worker was terminated from Department employment.

Case #9

The OIG investigated a complaint that a child protection investigator exhibited bias against the parents' religious beliefs. During a shelter care hearing, the child protection investigator stated to the judge that because of the parents' religious affiliation it was likely they would attempt to hide the children from the Department. The OIG referred the case to the United States Attorney's Office for review of possible violation of the Civil Rights of the family. The case was also referred to the Illinois Attorney General's Office as it appeared that a worker had lied under oath to the Court. The referrals are still pending.

Case #10
A former foster parent and subject of a prior OIG investigation called the Governor's office and threatened to "blow-up" a Department office. Central Management Services police investigated the threat, but did not refer the matter to the Illinois State Police. Central Management Police reasoned that the threat was not direct because the foster mother had not stated that she would blow up the building, only that "someone" might. The OIG ensured that all offices that might have been possible targets for retaliation stemming from the case were notified and provided with recent photographs of the former foster parent.

Case #11
A woman forged foster care checks. She cashed the checks over a period of time for an accumulated sum over $22,000. The OIG referred the investigation to law enforcement for investigation. The woman was criminally prosecuted and pled guilty. She was sentenced to 21 months imprisonment and ordered to pay full restitution to the state of Illinois.

Case #12
A preliminary investigation by the OIG revealed that a Department administrator misused 16 days of sick benefit time to provide paid consulting services. The OIG referred the employee to the Illinois Attorney General for official misconduct. The referral is still pending. The employee was terminated from the Department.

Case #13
The OIG assisted the Illinois State Police (ISP) Division of Internal Investigations in their investigation of a Department administrator for using her position to fraudulently obtain extensive services for her own children. The ISP was unable to verify the complaints regarding the fraud.

OIG INITIATIVES

ETHICS

Child Welfare Ethics Advisory Board

The Child Welfare Ethics Advisory Board met four times during FY 2003 to consider issues presented to it by child welfare professionals and by the OIG Ethics staff.[5] At its first meeting, the Board considered a question raised by the Executive Director of a not-for-profit agency that contracts with DCFS. DCFS licensing regulations prohibit agency board members from deriving or appearing to derive a profit or gain by reason of their board membership. The inquiry asked whether deeply discounted legal services provided by an agency board member would violate the rule. A DCFS administrator who participated in drafting the rule attended the meeting and pointed out that the rule was designed to prevent flagrant profiteering. She and the Board members discussed ways in which the rule could be changed or procedures put in place to provide an independent review of proposed transactions involving agency board members.

The Board reviewed a case that was the subject of an OIG investigation. A lifelong DCFS ward with a history of violence and mental health issues was placed in an independent living program after a series of failed residential placements. The ward then allegedly murdered another DCFS ward who was her neighbor in independent living. The Ethics Board members agreed that DCFS' failure to provide adequate placement options for highly aggressive wards was a serious ethical lapse. DCFS has a fiduciary responsibility to provide appropriate levels of care to meet the needs of the children in its custody. The Board also questioned the alleged "no decline" policy of the agency running the independent living program. Board members concurred that an absolute no decline policy was unethical since the agency did not have the capability of serving every child's needs; moreover, the Board felt that it was unethical of DCFS to accept such a policy on the part of the contracting agency. The Board also questioned whether DCFS' failure to provide secure facilities in Illinois after bringing children back from secure placements in other states was ethically defensible.

The Board raised the question whether it was ethical to force wards to take psychotropic medications if they refused them. Dr. Ozar presented a five step ethical framework for determining whether a person is capable of making decisions, and if not, how to determine, if possible, what the person would choose if she could, based on her prior value system. The Inspector General incorporated this and the other Board concerns into her report to the Director on this investigation.

Another OIG investigation generated an inquiry to the Board about professional ethics in a multi-disciplinary setting. In this case, an OIG investigator disagreed with a police officer's decision not to pursue charges against a possible perpetrator of sexual abuse against two young girls. The Board noted that a decision whether it is appropriate to pursue questions between disparate professions should be made

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[5] As of July 1, 2003, the members of the Child Welfare Ethics Advisory Board were:
Roberta Bartik, J.D., Commander, Youth Investigations Division, Chicago Police Department
Michael Bennett, Ph.D., Director, Msgr. John J. Egan Urban Center, DePaul University
Michael Davis, Ph.D., Illinois Institute of Technology's Center for the Study of Ethics in the Professions
Jimmy Lago, MSW, MBA, Chancellor, Archdiocese of Chicago
David Ozar, Ph.D., Director, Center for Ethics and Social Justice, Loyola University Chicago
Ada Skyles, Ph.D., J.D., Fellow, Chapin Hall Center for Children, University of Chicago (Chair)
Eugene Svebakken, MSW, Executive Director and CEO, Lutheran Child & Family Services

by a supervisor or administrator who is in a position to raise the issue with representatives of the other profession. Cdr. Bartik volunteered to be the liaison to the Chicago Police Department in this instance to determine whether the officers behaved ethically.

The Board drafted a letter to Governor Blagojevich and the new DCFS Director, Bryan Samuels, to familiarize them with the Board's existence and to describe the outstanding ethical issues of concern to the Board. Among these issues are: (1) DCFS' failure to accept hotline calls based on dependency, where a parent or other legal guardian of a child is incapable of caring adequately for the child, often because of physical or mental disability; (2) the need for assessing the decision-making ability of wards between ages eighteen and twenty-one, deciding on their behalf where appropriate, and planning for adult guardianship; (3) the complex clinical, liability and conflict of interest considerations in cases where DCFS wards become involved in the criminal justice system; (4) the ethical obligation to consider the needs of children born to DCFS wards and to establish a mechanism for assessing the parenting ability and wishes of teen parents, especially in high risk situations such as extreme youth or developmental disability of the mother; (5) the need for exploration of the patterns of prescribing psychotropic medications to DCFS wards, with particular attention to overmedication and inconsistent standards throughout the state.

OIG Ethics Staff Initiatives

The Ethics Coordinator made a joint presentation with a representative of the American Bar Association's Center on Children and the Law to the Louisiana State Child Welfare Conference in October 2002. The conference brought together supervisors and administrators of the state's child welfare department and representatives of the judiciary. The presentation described the Illinois child welfare ethics initiative and analyzed the ways in which child welfare ethics and legal ethics intersect in child welfare cases. In November 2002 Louisiana's Department of Social Services adopted a Code of Ethics for Child Welfare Professionals that is closely modeled on the Illinois Code written under the supervision of the OIG in 1995.

The Child Welfare League of America Press published the book Ethical Child Welfare Practice that was adapted by the OIG ethics staff from its earlier published handbook on ethical issues in clinical practice. The CWLA Press marketed the book to a national audience and the ethics staff received positive feedback from as far away as Japan. The ethics staff continued to work on a second volume addressing ethical issues in child welfare supervision and administration.

In November 2002, a breakfast was held at the University of Chicago to introduce a video training program developed by the OIG ethics staff in conjunction with the Department's Division of Training and Development, Governor's State University and the Park Ridge Center for Health, Faith & Ethics. The training package is entitled *Child Welfare Ethics Workshop: An Ethics Committee in Action.* Representatives from DCFS and several purchase of service agencies in Cook County attended the event. Some of these agencies have since begun to use the training program to help staff identify and think through ethical dilemmas. A similar presentation was made to DCFS and private agency personnel in Bloomington, Il. in March 2003.

As part of the implementation of OIG recommendations to the DCFS Director, the ethics staff conducted a training on "Recognizing and Minimizing Biases in Child Welfare Practice" in Bloomington for DCFS and private agency staff. Particular attention was given to the recognition of personal and cultural biases and strategies for their reduction, especially in a court setting.

The ethics staff also conducted three trainings at the request of purchase of service agencies. In each case, ethics staff met with agency administrators to identify ethical issues that commonly arise in their agencies, constructed a series of hypothetical case scenarios to reflect those issues, and presented the

cases at training sessions. Group discussions helped staff recognize the ethical values at stake and find ways to resolve them.

DCFS Ethics Officer

As Ethics Officer for DCFS under the Illinois Governmental Ethics Act, the Inspector General reviews the Statement of Economic Interest forms that senior DCFS employees are required to file by May 1 of each year with the Secretary of State. The Inspector General and the ethics staff noted entries that could constitute conflicts of interest and requested further information from filers. Outside interests were grouped in categories where appropriate and cautionary letters were sent to filers about ways to avoid conflicts of interest.

HOME AND FIRE SAFETY TRAINING

A home and fire safety training program was developed and implemented by the OIG Best Practice staff in response to a number of child deaths from fire and serious injuries resulting from other environmental hazards. In FY 02, the OIG reviewed 10 child deaths from residential fires, seven more than the previous year. Five of those children were in families that had intact family cases open at the time of the fire. The findings from these investigations prompted the OIG Best Practice staff to establish relationships with the Chicago Fire Department, the Lombard Fire Department Public Education Coordinator/President of the Illinois Youthful Firesetters Intervention Association, and Cook County Medical Examiner's staff to train workers on fire and home safety. The training curricula, designed for case managers, supervisors and licensing staff, provides practical home and fire safety information and strategies to help parents, caseworkers and licensing staff ensure the health and safety of intact families, wards and their child/ren. The curriculum also includes a manual entitled *A Helpful Guide for Young Parents and their Caregivers*. The manual and associated checklists are designed to be interactive tools used by workers during home visits with young parents and caregivers.

In FY 2003, approximately 415 licensing representatives, intact family workers and pregnant and parenting teen case managers in Springfield, Carbondale, East St. Louis and Bloomington participated in the two-day home and fire safety training. In Chicago, 20 pregnant or parenting teen wards and their case managers were trained at Maryville Dickens Shelter.

During FY 2004, the training will be rolled out in the Cook region. Trainings have already been scheduled in Chicago, Harvey, and Maywood. The training is currently being revised to meet the needs of child protection investigators.

ASTHMA INITIATIVE

Following the FY 99 and FY 00 OIG investigations of the deaths of six foster children with asthma, the Inspector General recommended that the Department train its caseworkers and children's caretakers on medically sound asthma practices. In response to the DCFS Director's request to assist in the implementation of this recommendation, the OIG developed a curriculum and initiated a training program for the identification of asthma and the means to obtain adequate diagnosis, treatment, and follow-up care. In FY 2003, the OIG Best Practice staff continued this program, training 287 Department caseworkers, 144 private agency caseworkers, and 236 foster parents. The OIG is presently transitioning management of the statewide asthma training program to the Department.

OLDER CAREGIVER PROGRAM

The Older Caregiver Program was initiated in response to a series of OIG investigations and the Department's review of foster homes caring for five or more children that revealed the implications of an aging care giving population on children's safety and permanency. The program was designed to address both child welfare and aging issues that arise in foster care, kinship care and adoptive/guardianship families involving caregivers 65 years old or older. The program employs a problem-solving model constructed from blended child welfare and geriatric perspectives and is comprised of three components: (1) comprehensive assessment of aging, child welfare, financial, and housing issues; (2) service provision that mobilizes resources for families; and (3) family conference mediation to enhance the family's problem solving capacities.

After initial development and field test of the program model by the Department and the OIG in FY 2001, Metropolitan Family Services in Chicago assumed implementation of the program. The following is the program evaluation for FY 2002 and FY 2003.

OUTCOME EVALUATION REPORT[6]

The "C" FAMILY

An Older Caregiver Program Case Study

Reason for Referral

An Adoption Preservation case manager referred Ms. C. to the Older Caregiver Program (OCP). While working with Ms. C and her adopted daughter, Mary, the worker suspected that Ms. C. had significant cognitive impairments, which prohibited her from adequately supervising Mary. The worker wished to utilize the expertise of the Senior Specialist to evaluate the situation further and explore resources to stabilize the placement.

Family Composition

Ms. C is a 74 year-old, African-American woman, who was caring for her 12-year-old adopted child, Mary. There were no other family members residing within the household. Ms. C. had one biological daughter who was deceased. She also had an adopted daughter (Mary's sibling) who was an adult living in St. Louis, Missouri. Extended family consisted of an elderly brother and sister-in-law, who resided within a few blocks of Ms. C. and another brother who lived in Wisconsin. Extended family support was very limited and relationships within the family were strained.

The initial senior assessment conducted on Ms. C. substantiated the Preservation worker's concerns that she was experiencing significant cognitive difficulties. Ms. C. scored a 13/29 on the Folstein Mini Mental Status Exam indicative of significant impairment. In addition, Ms. C. also reported that she suffered from hypertension, arthritis, vision loss from cataracts and some digestive problems

During the child's assessment it became apparent that Mary was responsible for maintaining the household. She completed most of the domestic chores including, cooking, cleaning, laundry and grocery

6 This report was authored by Neil J. Vincent, Ph.D., LCSW, Director of Outcomes and Evaluation, Metropolitan Family Services and Jean Xoubi, LCPC, Older Caregiver Program Director, Metropolitan Family Services.

shopping. Mary would also pay most of the bills. The child further mentioned that Ms. C. would often wander out of the house at night. In an effort to prevent this Mary often slept in front of the front door. Further concern for Mary's safety became apparent when she mentioned that men from the neighborhood would stay in the home periodically and often ask Ms. C. for money.

An attempt was made to conduct a financial assessment, however, Ms. C. was unable to provide any information about her current financial situation nor locate any documentation of assets or expenditures. While visiting the home, the financial specialist discovered that Ms. C. had tenants in an upstairs apartment who were not paying rent. Ms. C. wanted to evict them but was unable to initiate the process.

Identified family strengths included a strong bond and attachment between Ms. C. and Mary. Ms. C. explained that at one time she had been a foster parent caring for Mary's biological mother. Her mother remained with her for several years even after giving birth to two children. When Mary's mother left the home she continued to care for the two girls whom she later adopted. As a result Mary considered Ms. C. to be her true mother and provided gentle care for her. Unfortunately, this was a tremendous burden for such a young child.

Other Concerns

About one year prior to the Older Caregiver Program's involvement, Ms. C. sent Mary to St. Louis to live with her sister. She did not inform Mary's school or make arrangements for her continued education. Her prolonged absence resulted in Mary being held back a year once she returned. Also, Ms. C. informed Older Caregiver Program staff that Mary had been involved with the police in the past, as she had stolen checks from her purse. A neighbor had also forged Ms. C.'s signature. Mary was released into Ms. C.'s care and a referral was made to Adoption Preservation Program.

During the course of Older Caregiver family work, Mary became highly anxious about her future and began to manifest symptoms of Depression. She began spending less and less time at home preferring to stay at a friend's house. Ms. C. was unable to prevent her from leaving and staying out all night. On one particular occasion Mary attempted to enter the home with her friend. One of Ms. C.'s neighbors tried to prohibit this. A fight ensued which included use of weapons. The police were contacted and they transported Mary to a psychiatric hospital for further evaluation. Upon discharge, she was given a diagnosis of Intermittent Explosive Disorder; Depressive Disorder, Not otherwise specified; and Substance Abuse.

Interventions

Ms. C. was referred to the University of Chicago's Senior Health Care Center for a comprehensive geriatric evaluation. Her doctor had also recommended a neuro-psychological evaluation, which was performed by the department of psychiatry. The senior specialist accompanied Ms. C. to her appointments and subsequent consultations. The evaluation confirmed the OCP staff's initial findings. The geriatric evaluation determined that Ms. C. suffered from moderate to severe Dementia, probably of the Alzheimer's type, with a prognosis of 3-10 years. Furthermore, her doctor stated that Ms. C. was no longer competent to care for children, or make personal or financial decisions.

The OCP team recommended to DCFS that a full time homemaker be put in place to provide supervision to Mary while long-term arrangements were in progress. DCFS agreed to finance the homemaker service. Additionally, a referral was made to the Chicago Department on Aging for services to support Ms. C., including homemaker services and transportation to medical appointments.

The OCP senior and child welfare specialists provided brief, supportive, counseling to Mary to explain her mother's condition and help her process the impact it would have on both their lives.

Family conference mediation was held to explore placement options for Mary and whether any family members would serve as power of attorney for Ms. C. in an effort to manage her health care and finances. In attendance were both of Ms. C.'s brothers, sister-in-law, and Mary's schoolteacher and principal. Unfortunately, as her family members were elderly themselves there was no one who was able to commit to care for Mary or Ms. C. on a full time permanent basis.

The OCP team conducted a diligent search for relatives in and outside Illinois. With assistance from the St. Louis Police Department the team attempted to reach Mary's older sister. Unfortunately she had moved and left no forwarding address and she was not listed with the Department of Motor Vehicles.

OCP together with DCFS secured the necessary documentation to screen the case into Juvenile Court on a "no fault" dependency petition. Once temporary custody was granted to DCFS, the OCP worked with DCFS to locate a foster home in which the caregiver could effectively respond to Mary's needs while simultaneously supporting her relationship with Ms. C.

An Elder Abuse report for investigation was made in response to the allegations that neighbors were financially exploiting Ms. C.

Case Outcomes

A Cook County Juvenile Court Judge agreed with the Older Caregiver Program's recommendations that temporary custody of Mary be granted to the DCFS. Although this lead to a change in placement for Mary the move was planned in such a way that allowed both Ms. C. and Mary to be comfortable with the decision. The new caregiver was made aware of the uniqueness of the situation and was thus better able to provide the necessary emotional support Mary would need going forward. Plans for regular visitation were established prior to placement so as to support the close relationship that the mother and child had. The private agency managing the case was also able to set up therapeutic services (counseling, medication management, and therapeutic recreation services) in a timely manner.

Ms. C.'s doctor felt that she was no longer competent to manage her own affairs. Ms. C. did not trust her siblings with power of attorney. There were no friends or family members identified who could provide the level of supervision Ms. C. would need to remain safely in her home or community. Her physician, family members, and OCP staff noted concerns about her risk for continued financial exploitation. Although the Department of Aging was providing a homemaker, the number of hours she would be alone put her at risk. Her doctor felt she should move into a long-term care facility; however, Ms. C. was adamantly opposed to the idea. A decision was made to contact the Cook County Public Guardian's Office to initiate the process of having an adult guardian assigned. A court date was secured resulting in temporary guardianship (60 days) with a subsequent date set for permanent guardianship of Ms. C.

Once assigned, the OCP staff worked with the guardian, her relatives and two of Ms. C.'s banks to insure that no one else would have access to her accounts. Direct deposit of her SSI checks and withdrawal for gas and electric bill payments were set up and would occur automatically each month. The guardian's signature would be required for bank account withdrawals. A live-in, 24-hour, homemaker was put in place so Ms. C. would receive adequate supervision and support. Arrangements were made for Ms. C. to attend an adult day care facility, which provided recreation and leisure activities and increased social opportunities. Ms. C.'s guardian also arranged to have all the locks in the home changed so no one would have access to the premises and there are no tenants in Ms. C.'s building.

Background of the Older Caregiver Program

In 1998 a series of OIG investigations and Department reviews of foster homes caring for five or more children revealed implications of an aging care giving population on children's permanency and safety, and culminated in the development of a problem-solving model constructed from blended child welfare and geriatric perspectives.

The Office of Inspector General of the Illinois Department of Children and Family Services (OIG) and the Department of Children and Family Services (DCFS) initially developed and field-tested the problem-solving model (April 1999 – June 2000). At the start of FY2001, Metropolitan Family Services (MFS) assumed primary responsibility for implementation of the Older Caregiver Program with the collaborative support of the OIG and DCFS. The Department of Children and Family Services funds and monitors the program and contract. Staff from DCFS and the OIG are members of a workgroup that regularly meets to provide case consultation to the Metropolitan team and other professionals involved with the participating families.

The program was designed to address both the aging and child welfare issues that arise in foster care, kinship care and adoptive/guardianship families, involving caregivers 60 years old or older. The program assists families by involving older adults caring for children in order to sustain the care taking arrangement or to assist the extended family in making an alternative arrangement. The overall goal of the program is to ensure children's safety and permanency of placement and well-being of the older caregiver.

Program Model

The program employs an evolving problem-solving model comprised of three components: information gathering and assessment, provision of specialty services, and family conference mediation. Three assessment areas help to determine a family's needs: personal, social and parenting history; physical and cognitive status; and financial and housing concerns. The caregiver's relationship with the children in care is assessed across these areas and in terms of the child's developmental needs and challenges, education status, and the child's relationship with extended family. Task-centered service delivery is designed to address both child welfare and aging issues.

The program employs family conference mediation using the Illinois Family Conference model that was based on an approach developed in New Zealand. The primary features of the New Zealand family group conference model are the mandated involvement of family group members (significant blood and non-blood "kin" are included as family members) in child protection decision-making and a statutory created position (family coordinator) to convene, coordinate, and facilitate a family group decision-making process. The Illinois model integrates a task-centered approach and community mediation into the family conferences (Kane, 2001, Kane, et al, 1998). The purpose of the Older Caregiver family conference mediation is to enhance the extended family decision-making abilities and maintain an informal extended family support and protective system for at-risk caregivers and the children in their care. It is hoped that extended family members will more effectively support and monitor the safety and care of the caregiver and child. Family conference mediation is also designed to assist the extended family in making decisions and planning for alternative living arrangements for the child and sometimes the caregiver, if necessary.

At the family conference mediation, child welfare and geriatric specialists and other involved professionals share information, concerns and provide feedback to the family regarding the care giving arrangement, the child, and the caregiver's capabilities. The professionals then leave the conference and with the assistance of an independent mediator, the extended family engages in problem solving -

develops care and protection plans, back up care plans, and commit to tasks related to child safety and permanency and caregiver support.

Program Evaluation Plan

The Older Caregiver Program (OCP) evaluation initially began during the first year of the program implementation under Metropolitan Family Services. During that year, the program evaluator[7] conducted a process evaluation that documented the overall implementation of the program. The process evaluation identified important strengths and challenges of the program and lessons learned during the initial implementation year. Additionally, the process evaluation identified information about the families served by the program, including demographic data, presenting needs, strengths, and case studies. Finally the report offered recommendation for further development of the program.

The second year evaluation of the Older Caregiver Program focused on documenting program impact. The program evaluator, in collaboration with DCFS and OIG administrators, as well as researchers from the University of Chicago's School of Social Service Administration (SSA), designed an outcome evaluation to measure the effectiveness of the OCP. The outcome evaluation study employed a one-group pre/post-test design. There were no control or limited intervention groups. The consultant researchers from SSA provided consultation on the selection of the measurement tools used for the outcome evaluation.

The Metropolitan Family Services' program evaluator developed a program logic model that outlines the program components and evaluation. The program goals and objectives included in the logic model are the goals and objectives identified in the initial grant proposal. The outcome indicators were developed based on the program's objectives. The program evaluator selected the benchmark percentages cited in the outcome indicators based on the levels of success that are standard in the field of program evaluation.

The OCP has three identified **program goals**.

1. To address both the aging and child welfare issues that arise with children placed with older caregivers.

2. To ensure the permanency of the child's placement by maintaining the child in the current home or placing the child in a more appropriate home environment.

3. Maximize the safety of children and caregivers participating in the program.

In order to achieve the program goals, four **program objectives** were developed.

1. Implement a fully functioning Older Caregiver Program that provides the necessary support services to older caregivers and their children.

2. Resolve permanency issues for the participating families.

3. Increase the quality of the supports available to the family.

[7] The program evaluator for the Older Caregiver Program is Neil Vincent, Ph.D. Dr. Vincent is employed by Metropolitan Family Services and is responsible for conducting program evaluations of MFS.

4. Decrease the level of risk experienced by the family.

Measurable Outcomes: The program evaluator devised measurable outcomes with input from program staff and administrators *prior to conducting* the program evaluation. They serve as a benchmark to measure the level of success achieved by the program. Evaluation results for the four measurable outcomes are presented in the results section of this report.

1. A minimum of 40 families will be served through this contract and a maximum of 24 clients will be served in the program at any given time. (Note: this number has been increased in the FY 04 contract).

2. The OCP program will resolve issues of permanency for 75% of the participating families.

3. 70% of the families will experience a significant decrease in the level of risk experienced by the family.

4. 75% of the families will experience an increase in the quality of the supports available to the family.

Evaluation Method

Outcome Evaluation Design: At the start of the second year of the program, the program evaluator implemented a quantitative evaluation method to measure the effectiveness of the Older Caregiver Program. The outcome evaluation study employed a one-group pre/post-test design. The design does not have a control or limited intervention group. The evaluation measurement tools used in the study were administered at three points during the service process: during the assessment, at six months, and at case closing.

Evaluation Sampling: All families receiving services were eligible to participate in the evaluation process. However, data was collected only on those older caregivers that gave their consent to participate. A total of 26 families participated in the program evaluation.

Four measurable outcomes were identified and tracked to determine the impact of the Program. The measurable outcomes are directly linked to the program's overall goals and objectives. Table one summarizes the measurable outcomes studied in this evaluation.

Table 1: Measurable Outcomes for the Older Caregiver Program

Measurable Outcome	Outcome Measurement	Data Collection Method
1. A minimum of 40 families will be served through this contract and A maximum of 24 clients will be served in the program at any given time.	Data on number of families and client served was provided by the OCP supervisor	OCP supervisor submits end-of-year census statistics
2. The OCP program will resolve issues of permanency for 75% of the participating families.	Data on the rate of Permanencies achieved, obtained from the case closing report	Case closing report in the family's record
3. 70% of the families will experience a significant decrease in the level of risk experienced by the family.	Measured by the Family Support Scale (FSS)	The FSS was administered as a pre/post-test
4. 75% of the families will experience an increase in the quality of the supports available to the family.	Measured by the Child Well-Being Scales	The Child Wellbeing Scales was administered as a pre/post-test.

Outcome Measures: Three sources were used to collect data on the four measurable outcomes. They are: (1) the participant families' case records; (2) the Child Wellbeing Scales (CWBSs); and (3) the Family Support Scale (FSS). The Child Wellbeing Scales are copyrighted and cannot be reproduced. Information on the scale can be found at http://www.cwla.org/pubs/pubdetails.asp?PUBID=3062

- Case Records: The OCP staff opened a complete and comprehensive case record for each family receiving services. Data for the permanency outcome was collected from the case-closing summary of the case record.

- Child Well-Being Scales (Magura & Moses, 1987): The Child Well-Being Scales (CWBSs) is a nationally recognized and standardized measure of child well-being. The scales consist of 43 scales and 3 subscales that are used in the identification of family problems. The subscales of CWBS address child neglect, parenting skills, and child functioning relative to school performance and juvenile delinquency. CWBS's main focus is on the child, especially those children at-risk of or in placement situations, but it is most appropriately employed in program evaluation of child welfare services. In the evaluation of the OCP, 27 of the 43 CWBSs were used to measure the outcomes for level of risk and child well being. The 27 scales were chosen by the evaluator as the most relevant items for this Program. Prior to implementing the measure, the program evaluator consulted with program staff who validated the selection of these 27 items. OCP staff implemented the CWBSs at three time intervals: initial assessment, at the sixth month, and case closing.

- Family Support Scale (Dunst, Trivette, & Hamby, 1994): The Family Support Scale (FSS) is a caregiver self-report measure assessing the helpfulness of different types of social support when raising a young child. Examples of the 18 social support resources include parents, friends, social groups, school/day-care center, and professional helpers. Caregiver's rate the helpfulness of various social supports resources using a five-point Likert scale ranging from 1="not at all helpful" to 5="extremely helpful". For the OCP evaluation, the FSS was implemented at three time intervals: initial assessment, at the sixth month, and case closing.

Evaluation Results

Profile of Program Participants: Over the last two years, the Older Caregiver Program has served approximately 79 families. The average age of the older caregiver is 72.7 years old. Approximately 40% of the caregivers range in age from 71 to 80 years old. Caregivers age 60 to 65 years old comprised 22.9% of the total number of families served. Approximately 18% of the caregivers range in age from 66 to 70 years old. Three (3.8%) caregivers were over the age of 80. Of 123 children studied, 69% were between 6 and 15 years of age. Seventeen percent (17%) were under the age of 6 and 14% were over age 16. Table 2 and 3 summarizes caregiver and children data on frequency of age groupings, respectively.

Table 2: Frequency of eight age categories and mean age of caregiver (n=79 caregivers)

Age Category	Under 60	60-65	66-70	71-75	76-80	81-85	86-90	90+
Frequency (%)	2 (2.5%)	18 (22.9%)	14 (17.7%)	16 (20.3%)	16 (20.3%)	10 (12.7%)	2 (2.5%)	1 (1.3%)
Mean Caregiver Age (years)	72.7							

Table 3: Frequency of four age categories of children cared for by older adults (n=123)

Age Category	0-5	6-10	11-15	16-18
Frequency (%)	21 (17%)	37 (30%)	48 (39%)	17 (14%)
Mean Child's Age	10.23			

Approximately 68% of the caregivers supervise 1 to 3 children. Approximately 32% of the caregivers are caring for 4 to 8 children. On average, the older caregiver is caring for 2.62 children. These statistics show that in this sample, older caregivers care for large families. On average the caregiver is caring for 2.62 children. Table 4 summarizes the family size data.

Table 4: Frequency of the number of children in household and mean number of children per household (n=70 families)

No. of Chdn.	One	Two	Three	Four	Five	Six	Eight
Frequency (%)	23 (32.8%)	14 (20%)	11 (15.7%)	9 (12.9%)	8 (11.4%)	3 (4.2%)	2 (2.9%)
Mean No. of Chdn per Household	2.62						

Table 5 summarizes the legal status of the children enrolled in the Older Caregiver Program over the last two years. The overwhelming majority, 76.6% of the children were DCFS wards. A smaller percentage of children (14.3%) were in post-adoption and subsidized guardianship status. Only 9.1% of the children were in private guardianship.

Table 5: Legal status of children receiving services from the older caregiver Program* (n=71 families)

DCFS WARDS	POST ADOPTION/SG	PRIVATE GUARDIANSHIP
59 (76.6%)	11 (14.3%)	7 (9.1%)

* Some families have children with multiple status: Wards, adoption/SG & private arrangement children

Typically the families served by the OCP Program have a monthly median income of $1,435.00. Household income includes financial subsidies to the caregiver for the care of the children. Most of the older caregivers are female and all but one is African American. She has cared for her grandchildren for an average of five years. She is widowed and typically has an adult child living in her home in addition to grandchildren. On average the children living with the older caregiver are 10.29 years old and African American. A slight majority of the children in her care are male. Table 6 and 7 summarizes these demographic statistics.

Table 6: Family demographics

Demographic	Median
Monthly Household Income (includes all subsidies) (n=71 families)	$1,435
Demographic	**Mean**
Years of Caregiving (n=50 caregivers)	5 yrs. (mean)
Age of Caregiver (n=50)	72.7 yrs.
Age of Children (n=123)	10.23 yrs.

Table 7: Family demographics continued (n=71 families)

Demographic	Percent	
Gender of Caregiver	Female (97%)	Male (3%)
Gender of Child	Male (51%)	Female (49%)
Race of Caregiver	African American (93%) Caucasian (7%)	

Referral Information & Presenting Needs: It appears that the largest proportion of referrals came from private child welfare agencies (48.6 %), particularly the caseworkers and supervisors. Other prominent referral sources include: attorneys/juvenile court (15.7%) and DCFS caseworkers and supervisors (14.2%). Table 8 summarizes data for all referral sources.

Table 8: Referral Sources (n=70 families)

Source	Number of Families and (%)
DCFS (Caseworker/Supervisor)	10 (14.2%)
DCFS Post-Adoption unit	1 (1.4%)
Private Child Welfare Agency (Caseworker/Supervisor)	34 (48.6%)
Adoption Preservation Program	3 (4.3%)
Attorney/Juvenile Court	11 (15.7%)
Medical Provider	3 (4.3%)
DCFS Help Unit (at Juvenile Court)	1 (1.4%)
Internal (MFS) Program	2 (2.9%)
Client Self Referred	1 (1.4%)
Other: i.e. therapist	4 (5.7%)

Participant families are referred by community sources for many reasons. Of the reasons for referring families to the Older Caregiver Program, it appears that the need for an assessment of caregiver competency is indicated the most times in this sample of families. The need for back up care planning, caregiver health concerns, and needs of the child are indicated at nearly the same level, but far below assessment of caregiver competency. Next are housing assistance, financial planning, the need for senior services and caregiver mental health concerns. The list of reasons for referral shows the wide range of needs of participant families. Table 9 summarizes the frequency of referrals to the Older Caregiver Program.

Table 9: Primary Reasons for Referral to the OCP* (n=70)

Reason For Referral	Number of Times Indicated/%
Assessment of caregiver competency	35 (50%)
Back Up planning	21 (30%)
Caregiver health concerns	20 (28.6%)
Children's services needed	21 (30%)
Housing assistance	13 (18.6%)
Financial planning & support needed	9 (12.9%)
Senior services needed	8 (11.4%)
Caregiver mental health concerns	6 (8.6%)
Barrier to Permanency (i.e. criminal background)	4 (5.7%)

*** Caregivers presented with multiple issues at intake so percentages do not add up to 100%**

Children's Needs: Now that the State of Illinois is in year 5 of the permanency initiative, agencies are finding it even more difficult to achieve the required number of permanencies as required by their contract. Initially younger children, children placed with relatives and stable traditional placements of children without special needs were the first targeted for adoption or guardianship. The children who remain in the child welfare system tend to be older, part of a large sibling group, or have complex mental health, developmental, or physical needs. Thus children who have been referred to the Older Caregiver Program over the last two years came to the program with a multitude of complex issues that are difficult to resolve.

Many of the children participating in the program presented with emotional and behavioral challenges. Behavior problems (16.2%) related to sexually acting out, behavior disorders, and delinquency constitute the most common behavioral related presenting problems. OCP staff worked with seven families in which children presented with sexual behavior problems. In most cases the children

were reacting to their own sexual abuse victimization by acting out sexually with siblings or same aged peers. The OCP staff worked with one adolescent who was engaging in sexual predatory behaviors. A collection of DSM-IV Axis I diagnoses (14%) comprise the second most common presenting problem. Attention Deficit Hyperactive Disorder, Depression, Conduct Disorder, and Bipolar Disorder are the most prevalent in this sample of children. DSM-IV Axis II (8.1%) diagnoses are the third most common presenting problem. Pervasive Developmental Disorders including Mild, Profound and Moderate Mental Retardation, Cerebral Palsy, and Autism were prevalent in this sample of child participants. Table 10 summarizes the mental health problems most prevalent among children served by the Older Caregiver Program.

Table 10: Mental health problems most prevalent among children served by the OCP (n=123 children)

Mental Health Problem	Percent
BEHAVIORAL ISSUES	**16.2%**
Sexual Behavior Problems (Reactive & Aggressive)	**6.5%**
Behavior Disorder (IEP defined)	**5.7%**
Delinquency (Multiple status & adjudicated offences)	**4.1%**
Axis I Diagnosis	**14%**
Attention Deficit Hyperactivity Disorder	**5%**
Depression (Major)	**3.3%**
Conduct Disorder	**2.4%**
BI-Polar Disorder	**1.6%**
Adjustment Disorder, NOS	**.08%**
Anxiety Disorder, NOS	**.08%**
Bereavement	**.08%**
Depressive Disorder, NOS	**.08%**
Impulse Control Disorder	**.08%**
Psychotic Disorder	**.08%**
Axis II Diagnosis	**8.1%**
Mental Retardation	**5.6%**
Mild	**3.3%**
Profound	**1.6%**
Moderate	**.08%**
Cerebral Palsy	**1.6%**
Autism	**.08**

Presenting Needs of Older Caregivers: An analysis of the presenting needs of 50 older caregivers from families served in FY03 reveals that many of the caregivers adults referred to the OCP have significant physical and mental health concerns. The overwhelming majority of the 50 older caregivers included in this analysis suffered from heart disease (74%). The most common of these is hypertension followed by a history of heart failure. Sixty percent (60%) of the caregivers suffered from some other form of chronic medical condition. Arthritis, diabetes, hearing loss, kidney disease and osteoporosis are the most prevalent chronic conditions found among these older caregivers. Obesity, incontinence, thyroid condition, sleep apnea, high cholesterol and diverticulitis, a digestive condition were among the more moderate physical ailments assessed among the 50 older adults. Additionally, the older caregivers presented with past histories of colon, breast, stomach, and throat cancer, respiratory diseases, mobility problems, and visual impairment. Table 11 presents a summary of the medical problems presented by older caregivers in this sample.

Table 11: Presenting medical problems of older caregivers at assessment (n=50 caregivers)

Medical Problem	Percent
Heart Disease	74%
Hypertension	38%
Heart Failure	32%
Low Blood Pressure	4%
Other Chronic Conditions	60%
Arthritis	28%
Diabetes	20%
Hearing Impairment	8%
Kidney Disease	2%
Osteoporosis	2%
Other Moderate Conditions	20%
Obesity	6%
Incontinence	4%
Thyroid Condition	4%
Sleep Apnea	2%
High Cholesterol	2%
Diverticulitis (digestive condition)	2%
Cancer (By history-in remission	10%
Colon	4%
Breast	2%
Stomach	2%
Throat	2%
Respiratory Diseases	10%
Chronic Asthma	6%
Emphysema	4%
Mobility Problems	10%
Ambulates with assistance	8%
Not ambulatory	2%
Visual Impairment	8%
Mild to Moderate Impairment	6%
Legal Blind	2%

In addition to the medical conditions, a proportion of the 50 older caregivers presented with significant mental health problems. The most common of these is mild cognitive impairment (6%). Four (4%) percent presented with more severe forms of cognitive decline notably dementia. Depression and alcoholism were present in 4% and 2% of the older caregivers, respectively. Table 12 provides a summary of the mental health problems.

Table 12: Presenting mental health problems among older caregivers at assessment (n=50 caregivers)

Mental Health Problem	Percent
Mild Cognitive Impairment	6%
Moderate to Severe Cognitive Impairment (Dementia)	4%
Depression	4%
Alcoholism	2%

The number of presenting problems identified at assessment can be an important indicator of how complicated and precarious the presenting situation of families served by the older caregiver's Program is. In the evaluation of the 45 families served by the OCP in FY03, 44% of the families presented two to three problems. Forty percent (40%) of the families presented four or more presenting problems with two families coping with seven or more stressors. See Table 13 for a summary of the number of families presenting multiple problems at assessment.

Table 13: Number of families presenting multiple problems at assessment (n=45 families)

No. of Families	7	10	10	9	4	3	2
# of Documented Presenting Problems/%	1	2	3	4	5	6	7+

Housing/Financial Needs: Many seniors in the program are living on a fixed income. The additional cost incurred of taking in children and the need for larger housing creates a tremendous strain on an already limited income. Although most receive a board payment or subsidy, the additional income barely offsets the cost of having the children in the home. OCP provided financial support to many families to meet basic needs such as furniture and appliances (beds, air conditioners, and smoke detectors); utilities; moving expenses (rent, security deposits); food, clothing, and transportation.

Housing was another area of need for families served by the OCP. Of the 45 families receiving services from OCP in FY03, 14 (31%) families received assistance with housing problems. The largest proportion of families lived in housing conditions deemed unsafe for children (13.3%). An equal proportion (4.4%) of families lived in housing with inadequate space, failed to adequately accommodate children with special needs, and were located in high-crime dangerous communities. A smaller but equal percentage (2.2%) of the families faced eviction/foreclosure and had their home damaged by fire. Table 14 provides a summary of the housing problems experienced by families served by the OCP.

Table 14: Housing problems presented by families at assessment (n=14 families)

Housing Problem	Percent
Housing condition unsafe for children	13.3%
Inadequate space	4.4%
Housing for special needs of child	4.4%
High-crime neighborhoods	4.4%
Eviction/Foreclosure	2.2%
Fire damage	2.2%

The budget analysis conducted revealed that (1) 22.2% of older caregivers had minimal understanding of their own financial picture or an inability to manage their household finances; (2) 11.1% of the families had financial problems due to expensive housing repairs and necessary renovations; and (3) 6.6% had credit problems that stressed their financial situation. 6.6% of the families were in jeopardy of losing their homes because of unpaid taxes.

The OCP staff assessed that 4.4% of the older adults had been targeted by unscrupulous lenders and were involved with predatory mortgages or loans. The OCP financial specialist was able to work with them to resolve these issues by conducting comprehensive financial assessments, advocating on behalf of older adults with creditors, educating older adults about financial management, and referring them to resources in the community that provided financial assistance. See Table 15 for a summary of financial problems presented by families served.

In addition to a comprehensive financial assessment, education, advocacy and referrals, the Older Caregiver Program provided direct financial assistance in response to family needs. The program provided $4,785 in ongoing rental assistance, $2,835 in moving expenses ($2,750 for security deposits and $85 for credit checks), $2,183 for furniture and appliances ($807 for air conditioners, $1,037 for beds/cribs, $279 for dressers, and $60 baby monitors), $1,039 in utility assistance, and $300 in emergency food and clothing assistance. The OCP also provided financial assistance for: $278 for respite care and geriatric evaluations, $83.78 for transportation services to OCP events, and $900 for holiday gift certificates. For FY03 a total of $12,403 in direct financial assistance was provided to participating families based on their presenting needs. Through Metropolitan Family Services, the older caregiver participated in support groups, special trainings, and the annual Christmas party.

Table 15: (n=12 families)

Financial Problem	Percent
Money management (budgeting, prioritizing, and saving)	22.2%
Housing expenses (renovation and repair)	11.1%
Credit problems	6.6%
Delinquent property taxes	6.6%
Predatory lending	4.4%
Bankruptcy	4.4%

Measurable Outcome Results

Outcome 1: *A minimum of 40 families will be served through this contract and a maximum of 24 clients will be served in the program at any given time.*

Over the last two years, the OCP has served approximately:

- 79 families since its inception.
- 45 families received services in FY03 and 16 families ended services.
- During the second half of FY03 the OCP reached capacity and formed a waiting list.
- Currently there is approximately 26 families waiting to receive services as a result, as a result DCFS increased funding and expanded the service catchment area of the program for FY 2004.

Outcome 2: *The OCP program will resolve issues of permanency for 75% of the participating families.*

Of the 16 families who received services and whose cases were closed in FY03,

- 100% had a successful resolution to issues of permanency.
- 50% percent of the children remained with the senior caregiver but had a back up care plan established.
- 50% of the families had children removed and placed in an alternative living arrangement. The primary reason for placement out of the caregiver's home was the caregiver's medical/cognitive disability or the child's special needs exceeded the ability of the caregiver to manage parenting tasks.
- The Older Caregiver Program was able to exceed the projected level of 75% for this measurable outcome. Permanency issues were successfully resolved for all of the families that reached termination in FY03. This accomplishment did not only secure care for the children, but it also increased the safety of the child by stabilizing the care they receive from those responsible for their needs.

Outcome 3: *70% of the families will experience a significant decrease in the level of risk experienced by the family*

The Child Well Being Scales (CWBS) measured changes in the level of risk experienced by the family. In the evaluation of the OCP, 27 of the 43 CWBSs were used to measure the outcomes for level of risk and child well being. OCP staff used the CWBSs to rate the families' level of risk at three time intervals: initial assessment, 6th month, and case closing. The scale uses mostly a 5-point (6-point scale on a small number of items) continuum where a rating of 1 indicates an ideal condition and 5 rates the poorest state of well being and highest level of risk.

To measure level of risk, five items were analyzed. They are: security of household, physical safety in the home, supervision of children in care, money management and parental capacity for

childcare. Change in level of risk was measured by analyzing the pre and post-tests scores on each of the selected items. Only five of the twenty-seven scales were analyzed because missing data in twenty-two of the scales precluded a meaningful analysis.

- Outcome results show that there was no change in the level of risk for 26 families as measured by the CWBSs.

The primary reason for the lack of change in the level of risk is that OCP staff rated families as low risk at the pre-test. The mean scores for all of the items analyzed as indicators of risk were near 1.00 with the exception of money management. Table 16 summarizes the pretest score for the level of risk items. There is an apparent contradiction in the level of risk assessed by OCP staff and the 50% rate of placement disruptions cited in outcome 2. A placement disruption clearly indicates a level of safety risk.

Table 16: Pre-test scores for level of risk (n=26)

Item	Mean	Standard Deviation
Security of Household	1.22	.441
Physical safety in the home	1.07	.267
Supervision of younger children	1.30	.949
Money management	2.22	1.09
Parental capacity for care	1.60	1.07

The low levels of risk as indicated by the pretest mean scores stand in contrast to the data summarizing the presenting problems outlined above and the 50% placement disruption rate. Use of the Child Well Being Scales as a measure of child risk and well being was clearly problematic in this evaluation. First, there was a significant amount of missing data from pre to post-test. This precluded a meaningful analysis of the proposed 27 scales. After accounting for missing data only 5 scales could be analyzed. A second problem with using the CWBSs in this evaluation had to do with validity of OCP staff's rating as to the level of risk presented by families. OCP staff view the older adults from a strengths-based perspective and are strong advocates for older adults. They have a strong reluctance to view older adults in terms of deficits even though problems maybe apparent. This prevailing paradigm may have lead to the inaccurate rating of the older adult caregivers in this sample as low risk when they may have been in fact at high risk.

Outcome 4: *75% of the families will experience an increase in the quality of the supports available to the family*

Older adults in the program reported the quality of the social supports they receive by completing the Family Support Scale (FSS). The FSS asks respondents to rate the quality of 19 sources of support on the following continuum: (1) not at all helpful; (2) occasionally helpful; (3) helpful; (4) more helpful; (5) very helpful. A sample of twenty-six older caregivers who received services during FY03 completed the pre/post FSS and recorded changes in the quality of the social support they receive. Although the FSS covers 19 sources of social support, not all of the sources apply to older adults. For instance, none of the older caregivers could rate the quality of the social supports given by their parents. Spouses, spouse's parents, nor friends of spouses applied to the program participants. The key sources of social support older caregivers reported as relevant are: relatives/kin, friends, children, church members/minister, professional helpers/social workers and teachers, and professional agencies: public health and social services.

The results for outcome 4 are reported only for those sources of support chosen as relevant by the older caregiver. An increase in the quality of social support was calculated by determining the percent of older caregivers who self-reported an improvement. The change was determined by analyzing pre-test FSS and post-test FSS.

- 62% of 24 older caregivers reported an increase in the quality of support from professional helpers, primarily the OCP staff social workers and other professional helpers such as child welfare workers, attorneys, and advocates.
- 33.3% of 21 older caregivers reported an increase in the quality of support from professional agencies, such as juvenile court, child welfare agencies, social service organization, etc.
- 33% of 21 older caregivers reported an increase in the quality of support provided by relatives.
- None of the caregivers reported an increase in the quality of support provided by friends, children, or church member/ministers.

It appears that the OCP Program has its greatest impact in the improvement of the quality of supports provided by professional helpers (social worker and teachers). Although less significant, the OCP also appears to have an impact on the quality of supports provided by professional agencies and relatives.

For many reasons, the impact demonstrated with these sources of support is not surprising. OCP staff work to make child welfare professionals and organizations more responsive and helpful. Also, the role of the OCP staff cannot be discounted in this impact. The OCP team builds productive and helpful relationships with older caregivers. The team attempts to provide a corrective experience for families who are too often dissatisfied with the assistance they have received. Additionally, OCP staff work to improve relationships with relatives of the older caregiver using the Family Conference Model. The goal is to do more than to just establish a back-up care plan but to use family conference mediation earlier in program participation and more than one time for the family, when indicated. Through use of the Family Conference Mediation approach, the OCP attempts to strengthen overall family problem solving skills and enhance and maintain an informal extended family support and protective system for older adults and the children in their care.

The lack of impact in the quality of supports provided by children, friends, and church members also can be explained by the fact that caregivers already report that the quality of their relationships with children, friends, and church members is high. Analysis of the FSS pre-tests gives an indication of the how older adult participants rate the quality of the social supports that they identified as important. Relatives, children, friend, and church members are all rated as consistently helpful. Sixty-six percent of the older caregivers rate relatives as helpful to Very helpful. Seventy-one percent of the caregivers rate family friends as helpful to very helpful. Seventy-seven percent of the caregivers rate their own children as helpful to very helpful, with 59% rating them very helpful. Seventy-two percent of the older caregivers rate church members and ministers as helpful to very helpful. A high rating of helpfulness in these relationship Tables 17-22 summarize results of the FSS pre-test.

Table 17: Quality of social supports provided by relatives or kin (n=26)

Response	Frequency	Percent	Cumulative Percent
Not at all helpful	4	19%	19%
Occasionally helpful	3	14.3%	33.3%
Helpful	3	14.3%	47.6%
More helpful	2	9.5%	57.1%
Very helpful	9	42.9%	100%
NA	5		

Table 18: Quality of social supports provided by family friends (n=26)

Response	Frequency	Percent	Cumulative Percent
Not at all helpful	1	4.8%	4.8%
Occasionally helpful	4	19%	23.8%
Helpful	8	38.1%	61.9%
More helpful	3	14.3%	76.2%
Very helpful	5	23.8%	100%
NA	5		

Table 19: Quality of social supports provided by the caregiver's children (n=26)

Response	Frequency	Percent	Cumulative Percent
Not at all helpful	1	5.9%	5.9%
Occasionally helpful	3	17.6%	23.5%
Helpful	1	5.9%	29.4%
More helpful	2	11.8%	41.9%
Very helpful	10	58.8%	100%
NA	9		

Table 20: Quality of social supports provided by a church member/minister (n=26)

Response	Frequency	Percent	Cumulative Percent
Not at all helpful	4	19%	19%
Occasionally helpful	2	9.5%	28.6%
Helpful	10	47.6%	76.2%
Very helpful	5	23.8%	100%
NA	5		

Table 21: Quality of social supports provided by social workers and teachers (n=26)

Response	Frequency	Percent	Cumulative Percent
Not at all helpful	3	12.5%	12.5%
Occasionally helpful	5	20.8%	33.3%
Helpful	8	33.3%	66.7%
More helpful	5	20.8%	87.5%
Very helpful	3	12.5%	100%
NA	2		

Table 22: Quality of social supports provided by social service agencies (n=26)

Response	Frequency	Percent	Cumulative Percent
Occasionally helpful	3	14.3%	14.3%
Helpful	7	33.3%	47.6%
More helpful	6	28.6%	76.2%
Very helpful	5	23.8%	100%
NA	5		

Family Conference Mediation Outcomes

Since the program's inception, OCP staff conducted twelve mediation sessions for nine families. Eight families have had one family mediation session and one family had three mediation sessions. A total of 56 participants attended the twelve mediation sessions. This number includes the mediator, OCP and child welfare staff, other professionals and family members. During FY03, the primary reason for conducting family conference mediation had been to develop a back-up care plan. Other reasons included: to cultivate extended family support, to identify a new caregiver from within the family, and to develop a plan for a teen to prepare for independent living. Tables 23 and 24 summarize the statistics on family mediation and the rationale.

Table 23: Number of mediations conducted, families served and individuals in attendance

Number of Mediations Conducted	Number of Families Served	Total Number of Participants
12	9	56

Table 24: Presenting rationale for conducting family mediations

Rationale for Conducting Mediations	Percent
Back-up Care Plan	33.3%
Develop Extended Family Support	16.6%
Identify new caregiver within the family	16.6%
Independent living situation	8.3%

The family mediator implemented a Mediation Participant's Evaluation Form to determine the impact of the mediation on the participant's perception of their family situation. The evaluation form was given to all family participants. A sample of sixteen (n=16) evaluation forms were analyzed and reported here out of 56 total participants. The evaluations are anonymous so there is no method for determining who completed the forms.

- 75% of the participants reported feeling comfortable speaking during the mediation.
- 6.3% reported feeling "not at all" comfortable speaking during the mediation.
- 18.75% of the data was missing.
- 75% of the participants reported trusting the mediator "very much" (56.2%) or "somewhat" (18.8%).
- 6.3% of the participants reported that they did not trust the mediator "at all".
- 18.75% of the data was missing.
- 62.5% of the participants reported that the mediator "helped me understand the different parts of the problem".
- 37.5% of the data was missing.
- 75% of the participants reported that the mediator "helped us develop several solutions to the problems".
- 25% of the data was missing.
- 81.3% of the participants thought that the agreement finalized by the mediation process was "good for the child".
- 18.7% of the data was missing.
- 93.8% of the participants thought that the plan developed through the mediation process was "very likely" (75%) or "likely" (18.8%) to work.
- 6.2% of the data was missing.

The overwhelming majority of mediation participants reported feeling comfortable speaking (75%) during the mediation and felt trust (75%) in the mediator. This is significant given the fact that all except one family only had one family mediation conference. One participant neither felt comfortable nor trusted the mediator. This participant also did not complete the subsequent items on the evaluation form.

Based on the participants' surveys, the mediation process appears to have helped participants both partialize the family problems and develop multiple solutions: 62.5% of the participants reported that the mediator "helped me understand the different parts of the problem" and 75% reported that the mediator "helped us develop several solutions to the problems".

The mediation process also appears to have had positive impact on participants' permanency view of how the agreement will affect the child and whether it is viable: 83.1% of the participants thought that the finalized agreement was "good for the child". Additionally, 93.8% of the participants felt that the plan developed through the mediation process was "very likely" (75%) or "likely" (18.8%) to work.

Limitations of the Evaluation Design

Overall, caution must be used in interpreting the evaluation results. Biased sampling, random and systematic error, missing data and a lack of a comparison group represent significant limitations of the OCP evaluation design that prevent a direct link between program services and family outcomes.

Evaluation Summary

Overall, the OCP team was successful in achieving a positive impact in the lives of the older caregivers and their families.

- The team served the targeted number of families in FY03 and successfully achieved this outcome.

- The OCP team was successful in resolving permanency issues for all of the families that ended services in FY03. This achievement far exceeded the projected level for this outcome. It appears that the program is fulfilling its most important goal of stabilizing families and maximizing the safety of children and older caregivers by establishing continuity of care.

- There appears to be no documented impact in the area of decreasing the level of risk experienced by the family. The failure to show a decrease in risk appears to be related to the validity of staff's assessment of risk. The OCP staff rated the family's level of risk using the Child Well Being Scales. At the pre-test measure, staff rated families consistently as very low risk. A possible explanation is that OCP staff view families from a strengths model and advocate strongly for older caregivers. This practice orientation may have made staff reluctant to overtly rate families as having deficits and at risk.

- Although the program did not achieve the projected percentage of families reporting an increase in quality of social support, the program appears to have had a positive impact, particularly in improving the families' relationship with professional helpers, social service organizations, and relatives. The program did not appear to impact the quality of supports provided by friends, children and church members primarily because caregivers reported that the quality of these relationships were high before OCP became involved.

- Based on the participants' surveys, the mediation process appears to have helped participants both partialize the family problems and develop multiple solutions they may not have thought of before the mediation. The mediation process also appears to have had positive impact on participants' view of how the permanency agreement will affect the child and whether it is viable. The overwhelming majority of participants surveyed viewed the permanency agreement as good for the future of the child and is likely to succeed.

As a pilot program that struggled with implementation issues related to staffing and coordination of services during its first year, the Older Caregiver Program appears to have had a positive impact in helping older caregivers and their families better cope with difficult and complicated problems. The OCP team, including administrative staff from OIG, DCFS and Metropolitan Family Services as well as the direct service staff, has worked tirelessly and diligently to implement this much needed program.

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INTACT FAMILY RECOVERY PROJECT

The Intact Family Recovery (IFR) Project was initiated in 1998 in response to OIG investigations that highlighted the tragic consequences of providing inadequate services to substance affected families. Through a number of investigations, the OIG determined that generic intact services for families with substance affected infants resulted in insufficient contact with the families (on average 2 visits per month), inadequate service provision periods, a lack of substance abuse knowledge among workers and supervisors, and poor communication and follow through with treatment providers. These findings prompted the OIG to develop the IFR model. The Intact Family Recovery model (IFR) integrates child welfare and substance abuse disciplines to maximize child safety and effective participation in substance abuse treatment for intact families with a first or second substance-exposed infant. Basic tenets of the model include:

- immediate and increased communication and collaboration between child welfare and substance abuse treatment workers
- comprehensive services offered to the entire family
- intensive home visits by both child welfare and substance abuse providers
- cross training in both disciplines
- extended case management (18 to 24 months) in recognition of the difficult process of addressing drug dependency

The model imposes graduated sanctions to increase effective participation in substance abuse treatment. Graduated sanctions are imposed pursuant to a Memorandum of Agreement, or contract, between the workers and the parent(s) listing conditions and consequences for noncompliance. Graduated sanctions include prescreening or reviewing the case with the State's Attorneys Office and obtaining court orders mandating treatment compliance. Currently, the child welfare and substance abuse providers implementing the model in Cook County are Lutheran Social Services of Illinois (LSSI) and Recovery Point serving the North and South Cook regions; and Lutheran Children and Family Services of Illinois (LCFS) and Haymarket Center, serving the Central Cook region.

OIG Best Practice staff collaborated with The University of Chicago, School of Social Service Administration during FY 2003 to evaluate and interpret the project data. This project evaluation, *From Generalized to Specific Intact Family Services: Preliminary Findings From the Intact Family Recovery (IFR) Model*, was submitted to the Governor and the Director.

In FY 2003, the Department's Division of Service Intervention (DSI) assumed full responsibility of the IFR project. DSI currently provides clinical consultation at weekly staff meetings, identifies and confronts practice challenges, facilitates monthly supervisors meetings, coordinates and delivers training, and insures that private agency participants adhere to the project model. In FY 2004, Best Practice will review and evaluate IFR data collected after the project was transferred to the Department to assess project outcomes. OIG Best Practice staff will continue its monitoring of related recommendations and retain a small advisory role in private agency training and project evaluation.

From Generalized to Specialized Intact Family Services: Preliminary Findings from The Intact Family Recovery (IFR) Model

In recent years, a number of efforts have been made to promote the well-being of children by providing intensive services to children and their families within the home. As a group, these services are often referred to as intact family service programs. Intact family services are intended to improve family functioning thereby reducing further safety risk to children. In the State of Illinois, standard intact family service programs are configured as "full-case-responsibility casework services" in which the caseworker's responsibilities include counseling, parent training, advocacy, risk management and monitoring, and coordination of supportive services (OIG Report #960,020, p. 3, 1996).

The Illinois intact family services model was closely scrutinized by the Office of the Inspector General (OIG) following a number of cases involving severe abuse and tragic deaths of children in families receiving services from the Department of Children and Family Services (DCFS) where parental substance abuse was a contributing factor. Until recently, referrals for standard intact family services were assigned to agencies based on availability, and not necessarily on their ability to address the precipitating problem. As it pertained to parental substance abuse, no additional or differentiated services were suggested or indicated (OIG Report #960,020, p. 3, 1996). Many of the agencies were ill-equipped to coordinate cases where services to both the family and a substance-abusing parent were needed. This lack of treatment specialization and case coordination resulted in the fragmentation of services, which posed a risk to children residing in these families.

Parental substance abuse is an important problem facing the child welfare system. In fact, children of substance-abusing parents are the largest group of children entering the child welfare system (Barth, 1994; Besharov, 1994; Young et al, 1998). In order to provide a nationally representative estimate of both the number of pregnant women who reported the use of drugs during pregnancy and the number of infants born to these women, the National Institute on Drug Abuse (NIDA) conducted a nationwide hospital survey (NIDA, 1994). Survey results showed that 221,000 women used illegal drugs during their pregnancy that year. The number of babies born to these women was 222,000 (NIDA, 2002). In fiscal year 1999, the State of Illinois reported 1,645 indicated or substantiated cases of substance-exposed infants (SEI's) (IDCFS, February, 2000). Of these, 785 or 48% were subsequent SEI's (IDCFS, June 2000).

Children born to substance-abusing parents are at increased risk for a host of negative outcomes. Pediatric complications associated with prenatal substance use include neurological disturbances, prematurity, infectious diseases, fetal alcohol syndrome, sudden infant death syndrome, failure to thrive, intra-uterine growth retardation, and central nervous system disorders (US Department of Health and Human Services, 2002). These substance-exposed infants (SEI's) are also at increased risk for harm in the home. Researchers have found that children born to substance abusing women have a rate of physical abuse two to five times higher than matched children from similar backgrounds without a history of prenatal exposure (Chasnoff, 1998).

Unfortunately, traditional child welfare programs are ill equipped to deal with the challenges of working with substance abusing parents and protecting their children from harm. According to Besharov (1994), drug addiction is often viewed as a chronic, relapsing disorder that cannot be addressed by traditional child welfare programs because these programs are not designed to simultaneously respond to both the clinical needs of the substance-abusing parent and the safety needs of the children in the home. Given that the majority of children who come to the attention of the child welfare system will remain at

home and the increased likelihood of substance-abusing mothers to have subsequent pregnancies; alternatives to standard intact family services programs must be developed that include components to effectively address parental substance abuse.

Recognizing that the nature of intact family services with substance- effected families involves the concomitant tasks of safeguarding children from harm while providing supportive services to parents seeking substance abuse treatment, the Intact Family Recovery (IFR) model was developed and monitored by the Office of the Inspector General to address both of these issues. Guided by the intervention research paradigm advanced by Rothman and Thomas (1994), the IFR model is an amalgamation of state of the art child welfare and substance abuse practice approaches.[81] This article summarizes the IFR model and presents the results of its early pilot testing and subsequent implementation. These findings suggest that the IFR model is a promising child welfare model that can be used to keep families intact when risk of harm to children is caused by parental substance abuse.

The Intact Family Recovery (IFR) Model

The IFR model integrates child welfare and substance abuse disciplines to maximize child safety and effective participation in substance abuse treatment for families receiving intact services when the primary circumstances underlying the risk of harm to children is substance abuse. The IFR program has three primary goals: ensuring the safety of all the children in the home; parental completion of a significant course of substance abuse treatment; and enhancing the family's ability to promote the child's well-being.

Although the foremost purpose of the model is to ensure the safety of children, the model assumes that the best interest of children is served by keeping families intact and that families want to change, can change, and accept the responsibility for developing positive changes when appropriate supports and modeling are provided. Accordingly, the model is designed to assist families in meeting minimum parenting standards by assisting parents in remaining drug-free; to increase communication and collaboration between child welfare and substance abuse treatment providers; offer comprehensive services to the entire family; provide intensive home visits by both child welfare and substance abuse caseworkers; and cross training of staff in both disciplines. In Fiscal Year 2001, the cost of maintaining an IFR family (i.e. the participant, an average of three children per family, a spouse, and additional supports) was approximately $21,213 annually. However, according to the Fiscal Year 2002 Average Costs of foster care, it would cost the State of Illinois approximately $33,690 - $35,863 per year for these same three children. Therefore, IFR provides a dual role; keeping families intact, as well as ensuring children's safety, and decreasing costs to the state by approximately $14,000.

Referrals for IFR services in Illinois are initiated by Child Protection Services (CPS) Supervisors following a substantiated finding of neglect arising from either the birth of a first or second substance-exposed infant, or a finding of abuse or neglect involving families where the children are at risk of harm because of parental substance abuse. The determination of whether a family is suitable for intact family services is made by the CPS supervisor before a referral is made to IFR.

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[1]Rothman & Thomas' (1994) intervention research model provides a set of systematic procedures for designing, testing, evaluating, and refining social service intervention. Because its aim is to provide solutions to practical problems, Rothman & Thomas characterize it as applied research. The model converges aspects of previous research approaches that have been used to address the practice application of research, namely Knowledge Development (KD), Knowledge Utilization (KU), and Design & Development (D&D). D&D is regarded as the most salient component of the paradigm because it guides the generation of human service interventions. D&D includes six phases: problem analysis and project planning; information gathering and synthesis; design; early development and pilot testing; evaluation and advanced development; and dissemination. The D&D framework permits information from many sources to be used in constructing social service intervention models including information from related technology, legal policy, practice innovations, and personal and professional experience.

The IFR model recognizes that program-driven systems, differing agency missions, and conflicting time-lines and goals for families receiving services from child welfare and alcohol and other drug (AOD) agencies compromise the probability of successful outcomes. Therefore, the structure and services of the IFR model are integrated in that child welfare and substance abuse treatment providers are brought together in a collaborative effort for the overall good of families. Three child welfare and substance abuse treatment agency partnerships were established in Cook County to provide services to participating families. Since the model regards parental substance abuse as the family's presenting problem, the AOD agency assumes responsibility for substance abuse treatment and case management. Child welfare services are provided by child welfare agencies that have traditionally offered standard intact family services. Service providers in both agencies are thoroughly trained and work collaboratively to assist the family. The strength of this integrative approach is twofold: (1) it utilizes existing drug treatment and other community-based programs and services rather than duplicating these services within child welfare agencies, and (2) it decreases the likelihood of fragmented care. Table 1 lists the core principles of the IFR model (See Table 1).

Although IFR services are provided to families in a variety of settings and locations, child welfare services are largely provided in the family's home. As a result, IFR staff (i.e., child welfare worker, AOD case manager) travel to various locations to staff cases, meet with the parent or other family members, and to deliver program services. IFR staff also provides or coordinates transportation for families to ancillary and all other program services. Due to the integrative nature and structure of the IFR model, consistent and systematic communication between the child welfare and AOD partnerships is critical. Barriers to communication are quickly identified and addressed to ensure that program outcomes are achieved.

The IFR continuum of care encompasses three components: (1) Assessment, Referral, and Pretreatment; (2) Intensive Child Welfare, AOD, and case management Services; and (3) Aftercare and Maintenance Services. The program includes outpatient and inpatient substance abuse treatment, intensive case management and family services, medical and psychiatric referrals, and family and father services. Figure 1 outlines the types of service received during various stages of program involvement. A detailed description of each of these phases is provided below (See Figure 1).

In addition to developing the IFR model, the Illinois Office of the Inspector General was responsible for monitoring and supporting the partnerships. Methods for ensuring program fidelity and to thwart model drift included: weekly consultation at case staffings; convening monthly supervisory meetings to identify and address systematic and practice challenge; coordination and timely analysis of data collection to maximize opportunities for program adjustment and system correction; development of training curriculums and practice manuals to assist both disciplines in working with substance effected families; and the creation of tools to facilitate early family interventions, monitor child and home safety, and a matrix that includes both child welfare and substance abuse indictors of progress.

The Intact Family Recovery (IFR) Guidelines

Assessment, Referral, and Pretreatment

Following a referral from Child Protective Services (CPS), a meeting including the parent and family, the child protective services (CPS), child welfare worker, and an AOD case manager is convened in the family's home. This meeting commonly referred to as the Face-to-Face Hand-off involves reviewing the initial protective service complaint and the related investigative findings, explaining and discussing the IFR program and services, and ascertaining the substance abusing parent's willingness to participate. If the parent agrees to participate in the program, the AOD case manager completes a substance use assessment, makes a referral to a substance abuse treatment program and sets the beginning date for treatment. The AOD case manager provides preliminary services including: (1) beginning

treatment acceptance and readiness; (2) providing psycho educational informational to parents and family members about the addiction process and related family issues; (3) identifying appropriate self-help groups including referring family members to appropriate support groups, compiling a list of fellowship meetings, and assisting parents to make the proper choice.

The child welfare caseworker completes an assessment of: (1) child safety and well being; (2) the home environment; (3) parental functioning; (4) parent-child and other social relationships, and (5) family strengths and resources.

The child welfare worker is expected to have face-to-face contact with the family two times per week until the parent is actively involved in substance abuse treatment. Additionally, the child welfare worker responsibilities include coordinating home visits with the AOD case manager and actively participating in coordinating pretreatment services to the family including but not limited to planning for appropriate housing, making appropriate referrals for other social supports, encouraging and facilitating paternal involvement.

Although treatment is primarily the AOD case manger's domain, the child welfare worker continues to provide services to the family while supporting the efforts of the AOD case manager. Until the parent is actively engaged in treatment the team addresses barriers to treatment entry such as childcare and transportation, and works to insure proper postpartum health care. The goal is to ensure child safety, stabilize the household and prepare for the transition into treatment.

To facilitate communication among all involved parties and to ensure an appropriate transition into treatment services, the AOD case manager accompanies the parent to the first day of treatment. Once the parent begins treatment, it is expected that the AOD case manager and child welfare worker continue to assisted the family in arranging a system of supports to allow the parent to focus on successful completion of treatment rather than focus on managing the usual and often disruptive challenges that accompany entry into the child welfare and drug treatment systems. The AOD case manager visits the parent in treatment once a week and makes 2-3 phone contacts to directly monitor the parent's progress.

Workers are also encouraged to: work with mothers to reduce barriers to paternal involvement; contact extended family members and friends when mothers are reluctant to provide father identification; and when necessary utilize family conferences and mediation. It has been our experience that effective paternal involvement (i.e. spends quality time with the child, participates in child support system, takes child to spend time with his parents/relatives, brings diapers and other necessary items) is far more beneficial than just creating new programs or statements made in trainings supporting the engagement of fathers.

Intensive Child Welfare, AOD, and Case Management

This involves the provision of supportive child welfare, substance abuse treatment, and case management services. The child welfare worker performs various tasks associated with promoting the well-being of the children. Specifically, the Child welfare worker measures the parenting skills and attitudes of the parent observations of parent-child interactions in the home. Further, the child welfare worker initiates contact and forms alliances with the child care programs and schools the children are enrolled in, and conducts observational assessments of the children in these settings. For any child under the age of five, the child welfare worker coordinates an early intervention assessment, which includes evaluations of the child's cognitive, speech language, and motor development and skills. The child welfare worker also discusses the above-described assessments and service recommendations with all members of the IFR team, and makes arrangements for supportive services such as parent support groups, family therapy, and child mental health services.

While the parent is involved in intensive AOD treatment, the substance abuse treatment provider draws upon family collaterals as appropriate, and maintains contact with the IFR case worker and AOD case manager to discuss the parent's progress in treatment, particularly reporting the parent's successes and failures to comply with treatment. In addition, the substance abuse treatment provider assists the parent in selecting a sponsor and identifying self help programs both on-sit and in the community. The substance abuse treatment provider also makes treatment recommendations pertaining to the parent's need to be involved in such clinical services as domestic violence programs, family therapy, and couple's therapy. The AOD case manager extends case management services to the family, such as, facilitating weekly case staffings with the child welfare worker and substance abuse treatment provider for purposes of case discussion, treatment and service planning. Once a month the parent is included in case staffing.

Aftercare and Maintenance

As the parent approaches the end of substance abuse treatment, the substance abuse treatment provider informs the Child welfare worker and AOD case manager of the discharge so that a formal discharge staffing can be convened. The substance abuse treatment provider assists the parent in identifying supportive services for maintaining sobriety after treatment and developing relapse prevention plans. The AOD case manager reviews and discusses the aftercare and relapse prevention plans with the parent, and assists the parent in implementing the plans, and monitors the parent's participation in self-help programs. To monitor the parent's follow through with the aftercare plan, the AOD case manager also visits the parent twice per month for two months post discharge from substance abuse treatment and monthly thereafter requiring urine toxicology tests when necessary.

Given that child welfare services typically last longer than substance abuse treatment, the IFR model continues to provide services to the family following formal completion of substance abuse treatment. To ensure continuation of all ancillary services to the family and to monitor the parent's continued compliance with meeting the health and educational needs of the children following the parent's completion of substance abuse treatment, the child welfare worker meets with the family at least once per week for the first two months and bi-weekly for the life of the case. Should the parent relapse or other family concerns emerge, meetings with the family are scheduled more frequently.

Family cases are closed from the IFR program when the parent has successfully completed substance abuse treatment and the child welfare worker determines that minimum parenting standards are being met. Two weeks before case closure, the child welfare worker convenes and chairs the discharge planning conference. Attended by the parent, AOD provider, AOD case manager, and extended family members, the focus of this conference is the parent's progress, a review and update of the relapse prevention and collaborative service plans, and a discussion of strategies learned and skills developed by the parent to maintain the health and safety their child(ren).

METHOD

Setting

In an effort to provide integrated child welfare and substance abuse services to intact families who have recently given birth to a substance-exposed infant (SEI), partnerships have been established with two child welfare agencies, Lutheran Child and Family Services (LCFS) and Lutheran Social Services of Illinois (LSSI) North and South, as well as two substance abuse treatment providers, Haymarket Center, C-4 Recovery Point North and South. Services are collaboratively provided by child welfare and drug treatment case managers to coordinate and monitor family's progress. These agencies are structured to provide several levels of care ranging from home and child safety to intensive work with the client to enhance family unification and stabilize treatment. Services also include outpatient and

inpatient substance abuse treatment, intensive case management and family services, and psychiatric referrals.

Materials

The data on these measures were gathered using a variety of data collection instruments. The primary tool used is the IFR Data Checklist. These checklists contain information on all service tasks employed such as fathers identified, children's immunizations and school information, subsequent births and hotline calls, diagnoses, and court involvement information. A second tool is the Substance Abuse Treatment Table. This table details the past and current levels of treatment the participant has been involved in, the dates of admission and discharge, the reason for discharge, and the numbers of hours completed per each episode of treatment. DCFS administrative date is also used to verify demographic data; subsequent birth and hotline call information, and court involvement information.

RESULTS

The goal of this research was to explore the relationship between substance abuse and child welfare indicators, and treatment outcomes. We examined whether the substance-abusing parent completed a significant portion of treatment, gave birth to a subsequent substance exposed infant while in the program, and whether the Department of Children and Family Services (DCFS) took temporary custody of any children residing in the home during IFR project involvement. We analyzed our data at two phases of program implementation. The first phase, the pilot phase, was carried out between June 1998 and June 2000. Findings from the pilot phase were used to help fine-tune the model for data collection in the intervention phase of the program conducted between July 2000 and June 2002.

Pilot Phase (1998-2000):

During the two-year pilot phase, 187 referrals were made to the project by the state's Child Protective Services department (CPSW); 167 were enrolled. The age range of mothers participating in the IFR project was 18-47 with a mean age of 32. Seventy-eight percent of these mothers were African-American, 17% Caucasian, and 8% were Hispanic. The average number of children per family was 3.4. The ages of children participating in the IFR project ranged from less than one year to 19+ years. However, the majority of children are school age (57%). At the time of enrollment in the IFR project, 86% of mothers reported poly-substance use between eight and nine years on average. Cocaine and heroin accounted for 72% of the primary drugs currently used. Forty-three percent of mothers reported experiencing at least one prior substance abuse treatment experience beyond detoxification. Fourteen percent reported at least one detoxification experience.

During this pilot phase, the IFR project retained the majority of mothers in substance abuse treatment for a sufficient period of time to achieve long-term abstinence. According to the National Institute of Drug Abuse, persons with a moderate or severe substance abuse problem are significantly more likely to achieve long-term abstinence if they receive at least 90 days of treatment (NIDA, 1999). Sixty-four percent of mothers enrolled in the IFR project have completed ninety or more days of substance abuse treatment. This percentage includes a considerable percentage of mothers (48%) who have completed more than 120 days of treatment. Families remained in the program for 42 weeks or approximately 11 months following the parent's formal completion of substance abuse treatment on average.

With respect to court involvement, 29% of IFR cases resulted in Temporary Custody during the pilot period. Eleven of the 167 IFR mothers had subsequent pregnancies. Two of the births, or 1%, were delivered substance-exposed. Ten IFR cases were scheduled for closure by the end of the pilot period.

Intervention Phase (2000-2002)

During the two-year intervention phase, 158 referrals were made to the project by the state's Child Protective Services department. Of the 158 women referred, 129 agreed to participate in the Intact Family Recovery Program from July 1, 2000 through June 30, 2002; 227 families were enrolled. In addition, 98 women agreed to participate in the program before July 1, 2000 but continued to receive IFR services after this date; therefore, they were also included in the sample. Thus, our total sample is 227 women. The average age of mothers participating in the program was approximately 34 years old. Seventy-one percent of these mothers were African-American, 19% Caucasian, and 9% were Hispanic. Families had an average of 3 children. Nearly half of the mothers identified cocaine as their primary drug of choice; heroin was the primary drug of choice for 27% of mothers (See Table 2).

With respect to court involvement, Temporary Custody was taken in 55 of the 227 cases enrolled. Forty-nine percent of these Temporary Custody cases were identified as having criminal histories and in 38% of these cases, mental illness and domestic violence issues were identified as risk factors contributing to an unsafe environment in the home (See Table 3). In addition to the risk factors identified in Table 3, other factors that compromise child safety and contribute to temporary custody include: parents non-compliance with mental health treatment regimes, incarceration, parents being unable to meet the needs of a medically complex children, subsequent child abuse and neglect. It is important to note that 57% of our children were placed in a home with a relative and 3% were placed with their fathers.

Our findings suggest that the intensity and frequency of IFR home visits (2-3 times per/wk), coupled with ongoing communication between workers and substance abuse treatment providers have resulted in IFR workers being better able to identify and respond to child health and safety risks; recognize and respond to client cues for parenting, safety and treatment interventions, and monitor implementation of child health and safety measures. As a result of these intensive services risks to children that might go unnoticed are often discovered, when possible resolved, and when necessary temporary custody is sought.

Eighty percent of mothers enrolled in the IFR project completed ninety or more days of substance abuse treatment. Fourteen of the 227 IFR mothers had subsequent pregnancies during the intervention period. Three infants were born substance-exposed, representing approximately 1% of mothers in the intervention phase. One SEI infant died at birth. Forty-one percent of eligible three and four year old children were enrolled in a Head Start program and 77% of the children, 5 to 18 years old, were enrolled in school. Of the cases in which outcome data is available, 40% of cases have successfully completed the program (See Table 4).

In addition to collecting data on key outcome indicators, we also collected data on the partnership's adherence to the IFR model. According to the model, both child welfare workers and AOD case managers are to make multiple visits to the family each month throughout the program. For example, during Assessment and Pretreatment both child welfare workers and AOD case mangers are to visit the family at least once each week individually and at least once each week jointly. At a minimum, this means that a family should have a total of three contacts each week or at least 12 contacts each month in this initial phase of the program.

Table 5 lists the average number of client contacts made by child welfare workers and AOD case mangers in the Central Division for cases initiated after September 1, 2000. For the 27 cases on which we have the number of contacts for each of the first three months of treatment, child welfare workers made an average of 30 contacts and AOD case mangers made seventeen. Taken together, this is a total of 47 contacts in a three-month time span or an average of 16 contacts each month.

Figure 2 breaks these contacts down further into each month of treatment. As this figure shows, child welfare workers made more contacts with clients than AOD case manager in each month of treatment (See Figure 2). It also shows that, even at the lowest number of contacts (month 13), clients were receiving, on average, more than one contact each week. It should be noted, however, that contacts refer to visits and to phone calls and do not included collateral contacts or attempted contacts.

DISCUSSION

Children of substance-abusing parents are the largest group of children entering the child welfare system. Given that the nature of intact family services with substance-involved families includes the concomitant tasks of safeguarding children from harm and providing supportive services to parents seeking substance abuse treatment, the Intact Family Recovery (IFR) model was created to provide intact family services to families when the circumstance necessitating case initiation is parental substance abuse. Based on analysis of early pilot data and preliminary analyses of the intervention data, the IFR model shows effectiveness in retaining its participants in substance abuse treatment and keeping families intact. Since child safety is directly related to parental substance use, these findings do suggest that the IFR model is effective in reducing the risk of harm to children residing within intact substance-abusing families.

Future research using experimental designs is needed to further demonstrate the efficacy of the IFR model and should focus on isolating factors that lead to more successful outcomes. Reducing the number of unplanned pregnancies among substance abusing mothers is an important way to limit the stress placed on families and to prevent subsequent substance-exposed infant (SEI) births. Family planning is therefore an integral part of the IFR model. Eleven or 7% of all IFR mothers in the pilot period and approximately 6% of mothers in the intervention study had subsequent pregnancies. These subsequent SEI's represent 1% of all IFR mothers. While these rates are low, it is still an area in which the program can be improved. Following the analysis of the pilot findings, the treatment model was revised to include direct physician contact and more frequent urine toxicology's with pregnant mothers and mothers suspected of being pregnant. Although this does not seem to have reduced the overall percent of SEI's in the intervention phase of the study, it is possible that this increased monitoring may have played a role in increasing length of stay in treatment and overall family functioning as evidenced in the greater proportion of mothers completing 90 days of treatment and keeping their families intact.

Another area in need of further study is the role of fathers within these families. Fathers are noticeably missing participants in the child welfare system. Over time fathers have been systematically overlooked and marginalized by the child welfare system. Factors that constrain paternal engagement and involvement include: ambivalence of workers and supervisors about the benefits of paternal involvement, maternal reluctance to disclose information required for paternal diligent searches, system and societal questioning of resource allocation to men they view as the primary cause of problems facing children and families.

By not involving fathers, workers run the risk of failing to enlist the strengths that many men can bring to the parenting situation. When fathers become actively involved with their child(ren), they can have a positive impact on many aspects of a child's development; such as, helping to shape and reinforce the child's identity, self concept and esteem; and facilitating interaction between the child, paternal relatives and other extended family members. Paternal involvement has the potential to expand family support and child safety networks; and in the event that a child must be placed out of the home, paternal involvement allows workers to assess the father and his relatives for placement rather than placing the child in a non-relative home.

Research literature has historically paid little attention to fathers (Grief & Bailey, 1990) and there is an even greater paucity of child welfare literature on minority fathers. However, the literature points to the importance of offering services to fathers, such as job readiness training and parenting classes, to assist them in fulfilling a supportive role for their children (Bryan & Ajo, 1992; Wade, 1994). During the intervention phase of this study we began collecting data more systematically on the father's participation in treatment. Key findings from these data were that IFR workers contacted 80% of fathers identified; 93% of fathers contacted by IFR workers were offered supportive services; 42% of fathers offered services accepted referrals and supportive services; 54% of fathers accepting referral and supportive services completed recommended services; and 62% of the fathers contacted remained involved with their family.

Despite extensive research substantiating the effectiveness of alcohol and drug treatment, it appears that this type of treatment continues to be scrutinized. Belief systems about addiction, morality, and personal responsibility are hard to overcome, and the social stigma of alcohol and other drug use is reinforced through the very visible societal effects of use, namely, criminal activity and unhealthy social and familial functioning. As we learn more about the complexity of alcohol and drug abuse through the continued research and evaluation, we gain the tools to combat scrutiny. Evaluation of treatment helps us to understand the individuals in the treatment system, their personal characteristics, and the nature and severity of their problems. Specifically, one must continue to seek out effective, innovative approaches for treating individuals who have mental health histories and experiences with any type of abuse.

Due to the impact of women's substance abuse on families and society at large, it is essential that research in this area continue given the long-term implications for the physical and mental health of women and their families. If we, as a society and as treatment providers can help treat these women appropriately, we can attempt to diminish the possible ripple effect this abuse has on the lives of their children and keep more families intact; thereby decreasing the likelihood that this vicious cycle of abuse will perpetuate. Furthermore, due to the stigma, risk of legal intervention, and women's unique impact on society because of their roles as mothers, one needs to continue to encourage and support these women throughout their treatment and recovery.

The best treatment for problematic patterns of substance use is prevention, and considerable effort has been made in this regard. To achieve maximum success in the treatment of women, the approach must be tailored to meet their individual needs (Shaw & Gray, 1996). Efforts must be made to more widely disseminate available knowledge about the prevention and treatment of substance use by women and to apply it in clinical practice (Shaw & Gray, 1996). Thus, continued development of efficacious prevention and treatment strategies, such as the Intact Family Recovery Program, is necessary.

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Table 1. Core Principles of the Intact Family Recovery (IFR) Model

1. Services should be family and child centered;
2. Services should be holistic, and based on family and community strengths and resources;
3. Services should be culturally appropriate;
4. Services should be available and accessible using a continuum of care model;
5. Services should reflect a strong commitment to parent-child interaction with particular attention given to the child's psychosocial, developmental, and cognitive needs, and the child's sense of time and need for permanency;
6. Service delivery requires "fixed" responsibility for implementing the goals and practices of the IFR model;
7. Services should be designed to support successful drug treatment and compliance with child welfare service plans and permanency goals;
8. Outreach, inclusion and services for fathers to bridge the gap between the mother and child only dyad and expand it to incorporate the important role an involved father can play in creating a healthy family
9. Service goals must be measurable, with evaluation being an integral component of the model; and
10. Staff development must be extensive, collaborative, and ongoing.

Table 2. Sample Characteristics (N=227)

Characteristic	Result
Demographics	
Average Age of Parent	33.8
Percent African American	71%
Percent Caucasian	19%
Percent Hispanic	9%
Average Number of Children	3.04
Maternal Substance Abuse	
% Primarily Uses Cocaine	49%
% Primarily Uses Heroin	27%
% Primarily Uses Alcohol	9%
% Primarily Uses Marijuana	4%
% Primarily Uses PCP	2%

Table 3. Temporary Custody Findings (7/1/00-6/30/02)

Indicator	Finding	N*
% Of Temporary Custody Families	24%	55
% Of Children Placed in Home of Relative	57%	34
% Of Children Placed with their Fathers	3%	2
% Of Children Placed in Traditional Foster Care	33%	20
% Of Participants with a Criminal History	49%	27
% Of Participants with Mental Illness or Domestic Violence Issues	38%	21
*Mental Illness Issues Only	16%	9
**Domestic Violence Issues Only	16%	9
***Mental Illness And Domestic Violence Issues	.05%	3

Table 4. Outcome Findings (7/1/00-6/30/02)

Indicator	Finding	N*
% In treatment Over 90 Days or More	80%	125
% Of Families that Remained Intact	76	227
Number of SEI Births During Program	3**	
% Of SEI Infants in Sample	1.3%	227
% Of 3 &4 year old children enrolled in Head Start	41%	50
% Of 5-18 year old children enrolled in School	77%	266
% Of Cases Successfully Closed	40%	95

*Findings are based on the number of cases on which we have data and not necessarily on the total number of respondents in the sample.
**One of these three children died at birth.

Table 5. Average Number of Visits at Key Points in the Program (7/1/00-6/30/02)

Indicator	Finding	N*
Average # of Client Contacts Months 1-3**		
Child Welfare Face to Face **(In Home)**	15.6	27
Child Welfare Face to Face **(Out of home)**/Phone	14.2	27
AOD Face to Face	11.2	27
AOD Phone	5.5	27
Average # of Client Contacts Months 4-9**		
Child Welfare Face to Face **(In Home)**	26.3	17
Child Welfare Face to Face **(Out of home)**/Phone	28.1	17
AOD Face to Face	16.5	17
AOD Phone	2.2	17
Average # of Client Contacts Months 10-15**		
Child Welfare Face to Face **(In Home)**	14.3	14
Child Welfare Face to Face **(Out of home)**/Phone	14.6	14
AOD Face to Face	12.1	13
AOD Phone	1.2	13

*Only cases opened after 9/1/00 in the Central Division are represented. The number of cases represented decreases due to drop out and because data collection stopped after 6/30/02. The number of cases differs between child welfare and AOD in later months because AOD workers tended to close their cases sooner.
**These contacts do not reflect the 62 court contacts made, totaling a 185.5 hours.

Figure 1. Services Provided in the IFR Model

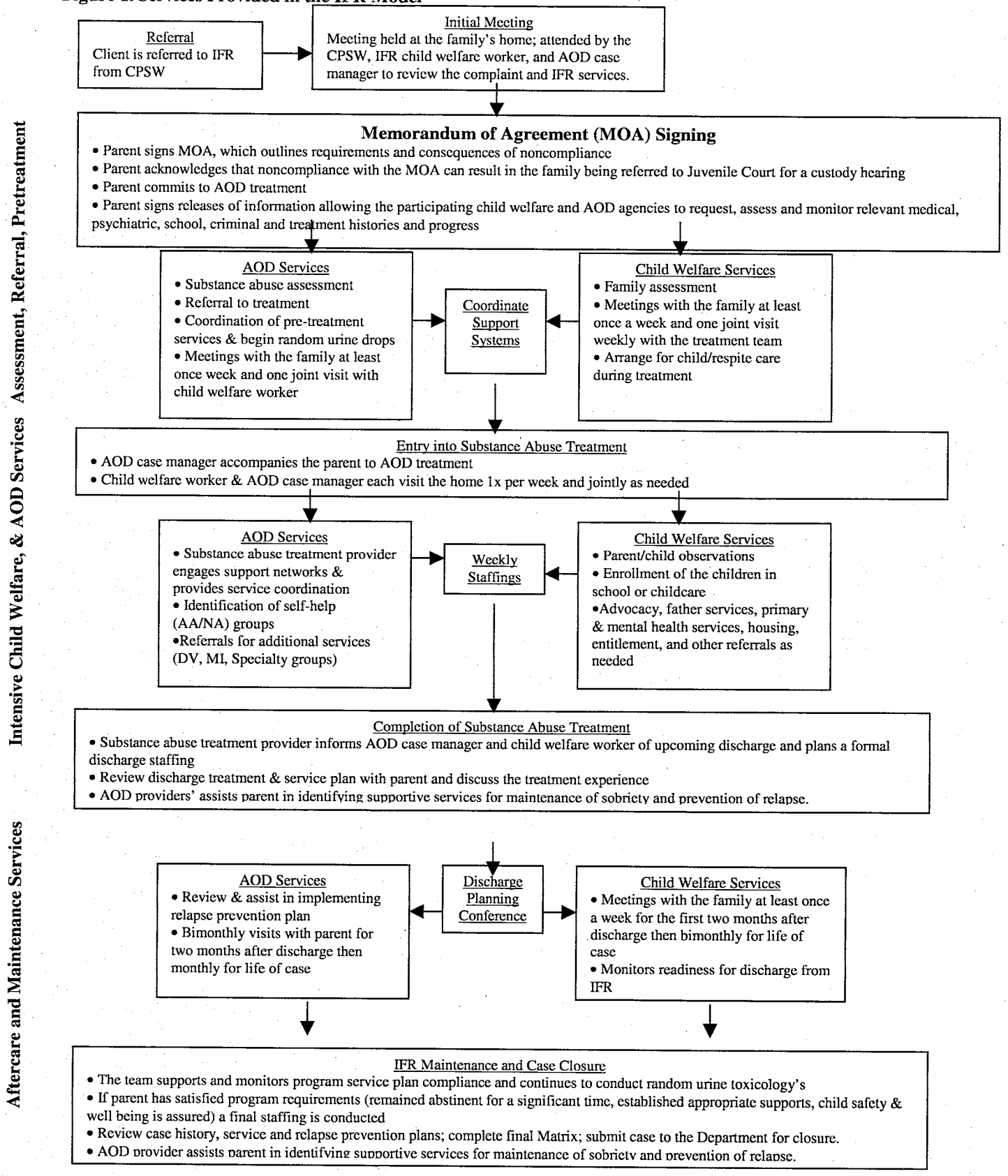
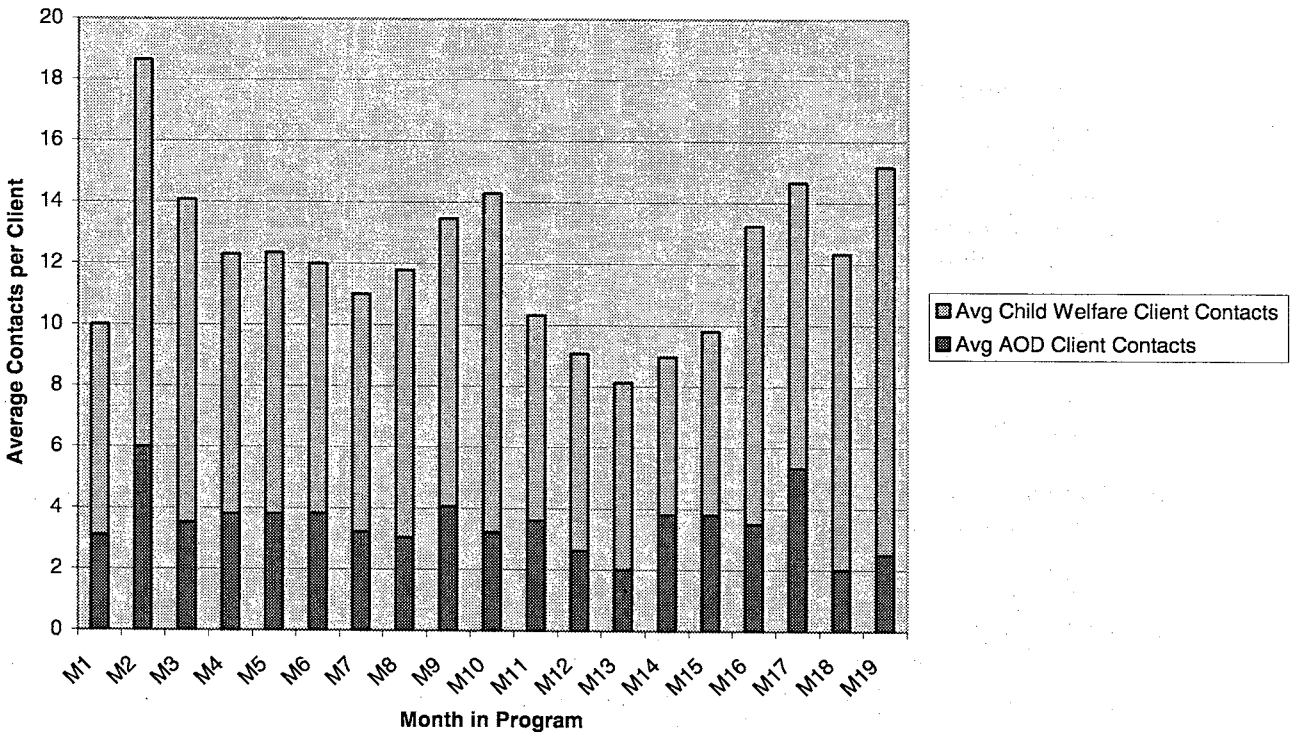


Figure 2. Average Child Welfare and AOD Client Contacts per Month in Program



RECOMMENDATIONS FOR DISCIPLINE

The OIG recommended discipline of Department and private agency employees for the conduct detailed below. Discipline recommendations ranged from counseling to discharge.

- A child protection investigator who knew of a previous serious abuse allegation of a six year-old girl in which the family had evaded the Department, failed to interview the reporters or perpetrator of a second abuse allegation and failed to screen the case into court when the parents evaded the Department a second time and kept the child from attending school. The six year-old girl was killed during the pending child protection investigation. The mother's boyfriend has been charged with first-degree murder. The OIG also recommended that the supervisor be disciplined.

- A private agency caseworker left an ill infant in the care of an eight year-old child and failed to call the hotline or document the incident in an Unusual Incident Report The caseworker also presented misinformation in three service plans in the case of a teenage ward charged with first-degree murder of her two year-old son.

- A Department employee on "proof status" for excessive absences submitted forged doctor's notes to support supposed illness-related work absences.

- A private agency supervisor failed to adequately supervise an inexperienced worker and neglected to instruct the caseworker to submit a special needs request to the Teen Parent Services Network or schedule a multidisciplinary staffing to address a parenting ward's continuing problems. The teen has been charged with first-degree murder of her son.

- A private agency caseworker failed to have monthly contact with her client or document problems the teenage parent experienced caring for her two year-old child. The teen has been charged with first-degree murder of her son.

- A private agency supervisor failed to ensure that her worker had monthly contact with the client and document problems with the teenage ward's child. The teen has been charged with first-degree murder of her son.

- A caseworker failed to contact relatives and past known caregivers in attempting to locate a runaway youth who was on run for over a month, was living with his girlfriend's family, and has been charged with murder of his girlfriend's one year-old brother.

- A Regional Clinical Coordinator disregarded the findings and recommendations of the Parenting Assessment Team evaluation which recommended that a seven year-old boy be removed from his home and conducted a substandard risk assessment without meeting with the family or reading the case record.

- A supervisor failed to document significant incidents in a case including a meeting with the family after the worker had reported the family to the hotline, failed to weigh the family's credibility prior to reassigning the case after the worker had called the hotline, and failed to call the hotline after a mandated reporter informed him that during a therapy session the child disclosed that the mother's paramour, "sometimes smacks me upside the head."

- A supervisor failed to ensure that the identified services for an intact family with a history of physical abuse were provided prior to closing the case, failed to read the case record, and failed to

ensure the caseworker addressed the risk issues or followed the recommendations in the Parenting Assessment Team report.

- A child protection investigator was found to have made unwelcome sexual advances to two teenagers, one of whom was a 14 year-old ward, and to have dated two adult clients.

- A Department employee intentionally filed a false hotline report against his former girlfriend and failed to cooperate with the OIG investigation.

- A child protection investigator investigated a child abuse/neglect report she had made.

- A child protection supervisor assigned a child abuse/neglect investigation to an investigator who observed the alleged abuse or neglect outside of her professional duties and reported the abuse to the hotline.

- A child protection investigator brought her boyfriend to a foster mother's home while on-call and responding to an off-hours child protection investigation.

- A Department administrator falsely claimed 16 sick days, allegedly to care for a sick family member, and used the time off to provide paid consulting services.

- A Department computer technician engaged in extensive sexually explicit chat room conversations with female minors over the internet.

- A caseworker obtained a driver's license from another state after his Illinois license was revoked, was absent from work for three weeks without authorization, and did not cooperate with the OIG investigation into his conduct.

- A DCFS attorney accessed the Department's computer database (CYCIS) for personal reasons and failed to notify his supervisor of a conflict of interest.

- A child protection supervisor failed to immediately transfer a case to a different office for investigation after he learned of a conflict of interest.

- A Department administrator accepted, responded to, and further distributed sexual and demeaning e-mails and used the Department e-mail system to send non-work related messages, often sexual in nature, to her boyfriend.

- A caseworker initiated a romantic relationship with a client and failed to notify his supervisor or the court of the relationship.

- A Department administrator assigned a child protection investigation to an investigator in the same office as the subject.

- A Department administrator accepted a personal loan from someone who is both a licensed foster parent and the spouse of a foster parent support specialist.

- A computer identification assigned to a government attorney was used to access inappropriate web sites during work hours.

EMPLOYEE LICENSURE CHARGES

Administrative Charges for Child Welfare Employee Licensure Action after OIG investigations disclosed the following allegations:

- Employee had a conviction for kidnapping which is a bar to licensure.
- Employee was fired from a private agency after allegations that she had appropriated funds from developmentally disabled youth on her caseload.
- Employee was alleged to have falsified medical documents for an Administrative Case Review and also alleged to have misappropriated Norman funds intended for housing assistance for clients.
- Private agency employee was alleged to have entered into an agreement with a client that permitted unsupervised visitation between father and children, despite knowledge of a court order prohibiting such contact. Employee also alleged to have failed to disclose prior conviction prior to being hired and falsified two letters of recommendation in order to gain employment.
- Private agency worker was alleged to have shared confidential client information with friend and permitted friend to pose as client to get state-funded services.
- Private agency employee falsified her background in order to gain employment. Employee had over 60 arrests and convictions for fraudulent activities.
- DCFS employee was alleged to have initiated and maintained intimate relationships with two clients of the Department. Employee was also alleged to have made unwelcome advances toward a missing ward, a non-ward minor and a disabled woman.
- Private agency employee was alleged to have misled employers regarding the extent of his criminal history that included approximately 30 convictions for fraudulent activities, drug related offenses and assault of a federal officer. Employee was also alleged to have engaged in a pattern of falsehoods through submitting a forged document to court, counseling a client not to share pertinent information with the court, and permitting unsupervised visitation with a family on his caseload, despite his knowledge of a court order prohibiting such visitation.

APPENDICES

Appendix A: Special Report on Violence Prevention

Appendix B: Nellie Paulsen Death Report (fictional name)

Appendix C: Infant Sleep Safety

OFFICE OF THE INSPECTOR GENERAL
Illinois Department of Children and Family Services

SPECIAL REPORT

TO THE GOVERNOR OF THE STATE OF ILLINOIS AND THE DIRECTOR OF THE ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

ON VIOLENCE PREVENTION

FEBRUARY 2003

Denise Kane, Ph.D.
Inspector General

Introduction and Background

The world remains a threatening, often dangerous place for children and youth. And in our country today, the greatest threat to the lives of children and adolescents is not disease or starvation or abandonment, but the terrible reality of violence.

Donna E. Shalala
Secretary of Health and Human Services
Youth Violence: A Report of the Surgeon

In a recent report from the Surgeon General (US Department of Health and Human Services, 2001) on youth violence, we are reminded that the "most enduring responsibility of any society is to ensure the health and well-being of its children." As the oversight body of the Department of Children and Family Services (DCFS), the Office of the Inspector General (OIG) is charged with the responsibility of ensuring that the Department never loses sight of this responsibility. This report will focus on OIG efforts to address issues of violence experienced by children and youth involved in the Illinois child welfare system. It draws heavily from our knowledge gained through investigations as well as on the Surgeon General's report and reports from other federal agencies as a template for how to conceptualize and address issues of violence confronting youth within the child welfare system.

Background

In the investigation process the OIG has encountered an alarming number of cases in which death and serious injury could have been prevented had professionals involved with these cases acted more knowledgably about risk factors for violence and strategies to prevent it. In this report, we summarize some of what we have learned from these investigations and offer recommendations to ensure that good practice procedures for preventing violence are established. This report pays special attention to violence both experienced and perpetrated by youth in the child welfare system. Although violence can mean many different things, we will use the term to refer to behaviors that result in serious injury to other persons. For purposes of this report, we will group areas of violence experienced by our youth in the following categories: First, violence that is perpetrated by caretakers after the child protection *investigatory* system missed signs that portend of future violence. Second, violence that is perpetrated against our children after the child protection system has investigated and determined that the child may be safely left at home with services *(intact service cases)* or has removed the child to a foster home *(placement service cases)*. Last, we will consider how the child welfare system responds to violence perpetrated by our own wards. There are some common themes and errors that occur across these categories that present implications for immediate changes in practices. For example, a problem solving approach gathers information and data on who, what, where, when and how to employ the best evidence-based solution whether the problem involves child protection investigations, intact family or placement interventions. If the child protection investigator or child welfare worker does not review underlying arrest documents on domestic violence incidents, neither the investigator nor the worker can effectively assess risk or design a safety plan. The purpose of this document is to offer the Governor and the Director of DCFS an analysis on violence in the context of the current child welfare system with the hope that by using available practice knowledge we can design a common multisystemic approach to reduce specific risk factors and increase protective factors.

Protecting Youth From Violence

According to a report from the US Department of Justice (2000), homicide is one of the leading causes of death among youth. In 1997, the National Center for Health Statistics listed homicide as the fourth leading cause of death for children ages 1 to 4, and third for youth ages 5-14, and second for persons age 15-24. In fact, of all the persons murdered in 1997, 11% were under the age of 18. In 2000, 78 deaths were attributed to child abuse or neglect in Illinois alone (Peddle et al., 2002).

The primary mission of the Department is to protect children who are reported to be abused or neglected and to increase their families' capacity to safely care for them (Illinois Department of Children and Family Services, 2002). In Illinois, the State Central Register (SCR) accepts calls reporting suspected child abuse or neglect by someone responsible for the child's welfare or by someone living in the home. Allegations are coded with a 6-digit, alpha-numeric code. The first allegation is designated "A." If indicated, meaning that evidence is found to support the allegation, the next allegation would end with the letter "B." Calls are categorized into specific categories for abuse or neglect investigation. The SCR maintains a list of all indicated perpetrators.

Another body, the Division of Child Protection (DCP), investigates allegations of abuse and neglect. After receiving a referral from SCR, a DCP investigator (also referred to as a Child Protection investigator or CPI) must make contact with the alleged victim within 24 hours. It is this DCP worker who must immediately assess risk to the child to determine whether the alleged victim and any other children in the home need to be removed during the investigation. Another DCP investigator will again assess the risk for children in the home, determine whether to indicate the allegation and may refer the case for additional services.

In recent years, the OIG has investigated a number of cases resulting in death or serious injury to children in which DCP or the agencies responsible for providing follow-up services have failed to adequately assess the risk of future violence to children. We will review a number of cases where the system failed to identify risks for violence and/or failed to implement strategies to protect youth from violence during initial DCP investigations or while providing services to the youth. Recurrent themes in these cases center on:

- The necessity of collecting sufficient information regarding the alleged incident to enable assessment of potential harm to the child (this includes relying exclusively on self-report information from the alleged perpetrator and failing to collect information from other important people in the child's life);

- The necessity of collecting sufficient information about environmental factors that are predictive of future harm to the child, such as domestic violence;

- Necessity to appreciate high risk of future harm when the presenting problem is abuse and parent is not cooperating with services;

Although investigations take place within the context of time constraints and often under adversarial circumstances, thorough information is paramount. Self-reported information from alleged perpetrators or those in relationships with alleged perpetrators is inherently suspect. Extended family or other indigenous sources are especially important in these instances. They may be able to provide important information on the child, the family, and other instances of suspected abuse that may not have been reported.

Indigenous sources may also be helpful to the investigator in determining the presence of risk factors for harm such as substance abuse and domestic violence (see Belsky, 1993 and Black et al., 2001 for reviews of risk factors for child maltreatment and physical abuse). Research has shown that children born to and in care of substance-abusing parents are at increased risk of harm. In a national survey conducted by the National Committee to Prevent Child Abuse, Lung & Darrow (1996) found that, among confirmed cases of child maltreatment, 40% involved the use of alcohol or other drugs. Child maltreatment and domestic violence also occur in tandem and, domestic violence is an important predictor for child maltreatment (Rumm et al., 2000; Tajima, 2000; McGuigan & Pratt, 2001). In their review of published studies on the co-occurrence of domestic violence and child maltreatment, Appel and Holden (1998) estimated a median co-occurrence rate of 40%.

In addition to gathering information from indigenous sources, the investigator must also assess the severity or longevity of the abuse under investigation. In complying with time constraints of an investigation, it is often the assessment that suffers. An investigator cannot know whether an indicated allegation should be screened into court for removal of the child or left as an intact family case with services if he or she has failed to assess the depth of the problem.

Studies have found that beliefs and attitudes toward corporal punishment are associated not only with physical child abuse potential (Crouch & Behl, 2001), but also with workers perceptions and reporting of child maltreatment (Ashton, 2001). Workers may minimize the potential for future violence when excessive corporal punishment is self-reported.

The following cases highlight these short-comings in the assessment of the risk for violence within the child welfare system. Following a review of these cases, a number of recommendations are offered to improve investigation practices and assessment of potential harm throughout service provision.

Case Examples*

COLLECTING SUFFICIENT INFORMATION REGARDING THE ALLEGED INCIDENT TO ENABLE ASSESSMENT OF POTENTIAL TO HARM TO THE CHILD

Gabrielle Ross

A couple was permitted to adopt two of their three grandchildren although the grandfather had a lengthy history of arrests. The three children, a 14 year-old boy and two girls, ages 6 and 3, had been placed in the custody of their maternal grandparents because of their mother's continued substance abuse and inability to provide adequate care. The grandparents had also served as a placement for a fourth grandchild who tested positive for cocaine at birth and died within one month of unknown causes.

The private agency caseworker initiated criminal and child abuse background checks of the grandparents. The grandfather had six arrests for assault and/or battery, one of which was for domestic battery, and one arrest for theft. Both grandparents claimed that the charge stemmed from an incident when the children's mother came to the grandparents' house while under the influence of drugs and the grandfather had to physically remove her from the home. The grandmother told the caseworker that the grandfather had never been abusive toward her or any of the children. The caseworker did not obtain the underlying documents and accepted the grandparents' accounts. The caseworker indicated that the grandfather's arrest history had been "cleared," meaning his offense was not sufficiently serious to prevent the children's placement and that the caseworker's supervisor had approved the decision. The case manager stated to the OIG that she did not consider obtaining the underlying police reports related to the grandfather's arrests but, if she had, she would not have known how to do so. An adoption supervisor subsequently approved the grandparents to adopt the two eldest children and to receive subsidies to assist in covering the cost of their care.

The OIG obtained the underlying police reports regarding the grandfather's arrests. The reports showed that the arrests were in fact the result of complaints against the grandfather that alleged violence against his wife, his adult children and, in one instance, a nine year-old girl, including reports of the grandfather's attack on his adult son with a knife and threatening the grandmother with a knife and gun during an argument related to the grandfather's use of drugs.

After reviewing the underlying documents obtained by the OIG, the case manager continued to minimize possible risks to the children in the home. The case manager stated she was unconcerned by the grandfather's threats because people "say things [they] don't mean in the heat of anger." The case manager did not determine whether the grandfather owned a gun and stated she was not concerned by reports of drug use because she believed the grandfather had issues related to alcohol consumption, although she did not refer him for a substance abuse assessment.

* All names have been changed to protect the identity of individuals involved. Cases have been summarized for the sake of brevity but every attempt was made to impart key facts on the case. Full redacted reports on these cases are available from the Office of the Inspector General.

The OIG recommended that the DCFS Domestic Violence Coordinator review this case to assess the appropriateness of the placement. The coordinator did not review the case record, consult the safety plan in place for the children, did not staff the case with the private agency employees familiar with the family, did not conduct a criminal background check on the grandfather or access underlying arrest reports, did not obtain a copy of the order of protection against the grandfather, did not contact the grandfather's probation officer, and did not interview the children in the home or the grandparents' adult children, one of whom had reported an incident in which the grandfather assaulted the son with a knife. The Domestic Violence coordinator and DCFS Clinical staff recommended maintaining this placement for the three year-old foster child.

At a subsequent home visit, the supervisor observed multiple bruises on the grandmother's face. The grandmother reported that her husband had beaten her a couple of weeks earlier. Given the extent of the bruising still visible after two weeks, the supervisor assessed that the grandfather did pose a risk to the grandmother and the children in the home. The private agency removed the three year-old foster child from the home and made a hotline call on the two adopted children for risk of harm. The hotline did not accept the call.

Peter Dempsey

Peter is a six year-old boy who died after being struck in the head multiple times by his stepfather. The boy's parents had been involved with services through the Department as a result of a previous indicated abuse report.

The Department initiated its involvement with the family after the State Central Register received two separate hotline calls claiming the boy had several bruises on his body and behaved strangely when questioned about them. The investigator assigned to the case contacted one of the reporters, a relative babysitter, who told her she noticed bruises on the boy since his mother's recent marriage. The stepfather regularly watched the boy on Tuesday nights and it was after these occasions when the babysitter noticed fresh injuries. The investigator observed a number of irregular bruises on the boy's face, torso and legs. When asked how the injuries occurred, the boy stated that the bruise on his face was caused by his stepfather body slamming him on his bed onto a toy truck. Some of the others were the result of accidents. After contacting her supervisor, the investigator took the boy into protective custody and, following a medical examination, placed him with his maternal grandmother.

The investigator then conducted separate interviews with the mother and stepfather. Both parents stated the body slamming incidents were part of a wrestling game the stepfather and the boy played and that the other injuries were accidental. The physician said that while he could not be certain the boy was abused, his bruising was "apparent and very suspicious". The child protection investigator indicated the case against the stepfather for cuts, welts and bruises and substantial risk of physical injury. The case was transferred to a private agency and the assigned caseworker began arranging services which included individual counseling, parenting classes and supervised visitation with the boy.

The caseworker reported visits between the boy and his mother were very positive. Another worker who took the boy to visit the stepfather reported the child was extremely apprehensive on the way to the meeting. The boy stated to the worker his grandmother told him

his stepfather was "bad" and had instructed the boy to stay away from him. The parents objected to what they perceived to be the grandmother's interference in the case.

Each parent was referred to a therapist for counseling. The therapist never effectively addressed the abuse.

In her sessions with the appointed therapist, the mother steadfastly contended there was no reason for the Department to be involved with her family. She maintained that her husband had never abused her son and that his injuries resulted from accidents and the rough behavior of the babysitter's children. The appointed therapist discharged the mother from counseling after four sessions because of her unwillingness to consider issues regarding the possible abuse of her son.

Shortly after the sessions were discontinued the boy was returned home and, seven months later, the family's case was closed. The system had never addressed the problems that had caused the boy to be removed: the inconsistent explanations of the stepfather, the boy's apparent fear of the stepfather and the importance of the mother's unshakable support for the stepfather. One year after the Department's involvement with the family ended, the boy was brought to a hospital with massive cerebral edema. The boy died from his injuries a few days later. His stepfather pled guilty to aggravated battery of a child and is currently serving a 20-year sentence.

COLLECTING SUFFICIENT INFORMATION ABOUT ENVIRONMENTAL FACTORS THAT ARE PREDICTIVE OF FUTURE HARM TO THE CHILD, SUCH AS DOMESTIC VIOLENCE

Evan Grant

Evan was a two and a half year-old boy who died after being pulled from a bathtub and shaken violently by his mother's live-in boyfriend. The boyfriend had been investigated for abusing the boy at a bowling alley seven months prior to the boy's death. The previous investigation was unfounded.

The initial abuse report was made after patrons at a bowling alley reported observing the mother's boyfriend periodically hitting and kicking the child at the bowling alley during the course of the evening. The boy was huddled against a wall with a coat over his head throughout the couple's time at the bowling alley. The patrons reported the behavior to the manager who subsequently contacted police. The boyfriend was arrested and charged with Battery of a Child and the boy was taken to a hospital for examination. The examining physician found no signs of abuse.

The investigator spoke to the arresting officer who related the initial information gathered by police. The mother denied to the investigator that her boyfriend had ever hit either of her children and stated she did not allow corporal punishment. The investigator interviewed the five year-old sister of the boy in the presence of her mother and grandmother. The girl stated she had witnessed the boyfriend strike her brother. The investigator noted that he observed the boy while

he was sleeping and that the mother stated there were no signs of abuse. The investigator did not conduct his own visual examination of the boy.

In a subsequent interview by telephone with a follow-up investigator, the mother stated her opinion that the entire situation had been a misunderstanding and that her son was underneath the coat because he was playing peek-a-boo. She further contended that the police did not give equal weight to her version of events and that she was told by others present at the bowling alley that some of the witnesses were motivated by their racial bias against her boyfriend. The investigator did not ask the mother to provide the names of any individuals who could support her contention. The investigator gave undue weight to the mother's denial of abuse and allegation of racial bias without verifying the information.

During the course of her investigation, the investigator failed to conduct interviews with the reporter or any of the witnesses from the bowling alley and did not complete a scene investigation. The investigator also neglected to make any attempt to speak with the boyfriend, verify the criminal charges against him or ascertain whether he was still in custody. Although an initial criminal history background check was conducted, the investigator did not request underlying documents which would have shown that while the boyfriend had no convictions, he had been arrested multiple times on numerous charges including simple battery, aggravated assault and domestic battery against family members and other cohabitants.

The investigator's supervisor instructed the investigator to initially unfound the case just one day after the case was assigned to this investigator and six days after the case was opened. The investigator documented that she unfounded the allegation because the witnesses' statements to the police were "inconsistent" with the reporter's initial allegation and the fact the attending physician had found no signs of abuse. The investigator never requested the boy's medical records from the hospital and no attempt was made to speak with the treating physician. Although available medical evidence has shown that physical evidence of trauma may not be detected for more than 48 hours after initial injury, no follow-up examination of the boy was ever conducted.

The investigator's supervisor stated to the OIG that he supported the investigator's conclusions. A review of the supervisor's evaluations showed his team completed 95 percent of investigations within 30 days (1/2 the time required by law), a level the evaluator noted greatly exceeded the Department's objective of 75 percent completion. Given the supervisor's approval of the minimal amount of investigation undertaken in this case, concerns were raised regarding the excessively high completion rate and its correlation to the quality of work produced by the supervisor's team.

Timothy Clarke

Timothy is an eight year-old boy who was allegedly beaten to death over the course of three weeks by his mother's live-in boyfriend. The boy's mother was out of state at the time of his death but was thought to have knowledge of the ongoing abuse that led to his death. Both have been charged with first-degree murder.

The couple, who was also the parents of a baby girl, had a previous indicated report in May 1999 for cuts, welts and bruises. At the time of the report, the boy told his teacher his

injuries had been inflicted by his mother's boyfriend and was worried that if the teacher told authorities, he would get in trouble.

The mother told the investigator assigned to the case that her boyfriend spanked the boy with a belt or extension cord for lying but she believed the punishment was too harsh and the couple agreed the boyfriend would not spank the boy with an instrument again. The investigator met with the boyfriend who said he had hit the boy because the boy was doing poorly in school and the boyfriend believed that academic performance was very important. The boyfriend acknowledged that he went too far. He assured the investigator the boy would not suffer any repercussions as a result of the Department's involvement. The couple, who were staying in the home of a friend at the time, told the investigator they had recently moved to Illinois from out of state and had no previous involvement with child protection agencies. The investigator accepted the boyfriend's presentation of a Certified Nursing Assistant Registration Verification issued by the Illinois Department of Public Health which appeared to show that he had no child abuse or neglect charges against him. The form was deceptive. In fact, the man had child abuse charges against him in Florida. The form was only intended to show that he had never abused an adult in a hospital setting. A criminal background check would have disclosed that the boyfriend had previous convictions for domestic violence. In addition, had the investigator interviewed the teacher about the child's school performance, he would have learned that the boy was a straight "A" student, and so the boyfriend's explanation for the beating was probably suspect. The investigator wholly accepted all the couple's self-reports and viewed his job as limited to assisting the couple with services, such as housing.

The investigator recommended indicating the case based on the boyfriend's admission and referred it to follow-up services. When the Department did not approve of the housing the couple found, the family claimed that the Department had lied to them and did not notify any involved workers of their whereabouts. The involved workers were eventually able to locate the family at their new home. The couple refused any further services. The follow-up worker's supervisor instructed him to close the case because the family's persistent rejection of any involvement with the Department.

This case represents a failure to appreciate competing hypothesis. An eight year old with welts and bruises may signify a one- time punishment gone awry or it may be a sign of an abuser who is out of control. We cannot base a determination of which scenario is correct solely on parents' or alleged perpetrators' self-report. It is understandable that a DCP investigator, under the pressure of short timelines, may choose a quick indication based upon a parents' admission. No one should presume, however, that the indication tells the full story. In this child's case no one ever determined the depth of the abuse problem.

DCFS data shows that that children who are 6 to 9 years old have the highest rate of reabuse. Children 6 to 9 years old have a re-abuse rate of .9 per 100 child years. Children under 6 have a .7 re-abuse rate and children 9 to 12 have a re-abuse rate of .8 again higher than the rate for children under six. Approximately 14% of cases come into the system for physical abuse.[9]

[9] The rates for the subset of re-abuse are rates based upon the re-abuse of the total number of children living in family cases in FY 99. The rate calculates re-abuse as a percentage of all children living in family cases which includes all allegations of abuse and neglect not only physical abuse. A better measure would track families (the

Knowledge of re-abuse rates on the 14% of children indicated for abuse would prove more practical to child welfare professionals. While school age children have more access to other adults and are verbal enough to tell someone when they are being injured, as with domestic violence cases, they may not speak up because of fear. The ability of a six, seven or eight year old to protect themselves is far below that of an adolescent.

Matthew London

Matthew is a five month-old boy who died as a result of internal bleeding caused by blunt trauma to the abdomen and head. The infant's father was convicted of first-degree murder. The OIG investigated this child's death because his family had an intact family case open at the time of his death.

Matthew came to the attention of the Department when a hotline call was made after the father brought the child into the mother's office and one of her co-worker's observed that the infant had two black eyes. The Child Protection investigator interviewed the mother's co-workers who stated it was "common knowledge" that her boyfriend physically abused her. They also suspected the father abused the child because they had previously seen bruises on the boy and heard statements by the mother that the father tied him to his crib. The investigator asked local police to go to the home that evening to check on the child and went out himself to meet with the parents the next morning. In both instances the father was cooperative and appeared very concerned. He and the mother told the investigator that the black eyes were the result of a bathing accident, though the mother had not been home at the time. They stated that the story of tying the boy to his crib was a simple joke that had been misinterpreted by her co-workers.

The investigator interviewed the couple's parents as well as teachers and students from the high school the couple had recently attended. All acknowledged the couple had a stormy relationship, which was exacerbated by the Caucasian female's parent's dislike for the African-American father. The investigator told the OIG that most of the interviewees, particularly the relatives, could have been influenced by racial bias. The biracial couple was living in a primarily white community. The investigator believed the only objective opinion was that of the child's doctor. The doctor said that child's injuries were consistent with the explanation provided and he felt the mother behaved appropriately when she brought the boy in for office appointments. The investigator concluded that there was insufficient evidence to indicate the report for abuse. However the investigator was concerned about domestic violence in the home and wanted the family involved with services. The investigator determined he could indicate the report for neglect based on the father's admission to another accident caused by his lack of supervision that resulted in bruises on the child. The investigator referred the couple for family preservation services through a private agency that was expected to begin working with the family immediately. The agency was to work with the father who lacked parenting skills and make unscheduled visits to monitor violence in the home.

On the second day of the investigation the investigator met with the family preservation therapist to discuss the case. The investigator gave the therapist a complete copy of the

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14% whose family comes to the attention of DCFS for physical abuse) who were reported and indicated with physical abuse allegations to determine what rate of those children are victims of physical re-abuse within a given period of time.

investigation and introduced him to the family. Over the following three weeks the therapist attempted nine visits but he met with family members only five times and on only one visit were they all present.

While the family was receiving intact services, the grandmother called the department to report that she "thought" she had seen bruises on the baby's back. Because of the grandmother's possible bias against the couple, the therapist went to the home to confirm the grandmother's allegations before notifying the hotline. Arriving unannounced, the therapist viewed the baby and saw bruises on the child's back, however the novice therapist was unsure whether such marks were signs of abuse or could have been caused in another manner. The therapist informed his supervisor who opined that there was nothing to warrant a hotline call.

The next morning the therapist and his supervisor reconsidered the situation with other staff. They determined that bruises on the back of a five month-old infant could not be accidental. The supervisor instructed the therapist to ask the grandmother to call the hotline because it would be more likely that the hotline would accept a call from a primary witness. After several hours the therapist reached the grandmother who was uncomfortable about calling and asked that he make the hotline call.

Before calling, however, the therapist went to the home for a scheduled visit. The mother wasn't home and the father told the therapist their son was sleeping. Concerned about upsetting the father, the therapist did not insist on viewing the infant. After leaving the home, the therapist called the hotline and was told a DCP investigator would go out to the home the following morning. One hour later, the father called 911 to request medical attention for his son. The boy was taken to a local emergency room where he was pronounced dead on arrival.

NECESSITY TO APPRECIATE HIGH RISK OF FUTURE HARM WHEN THE PRESENTING PROBLEM IS ABUSE AND PARENT IS NOT COOPERATING WITH SERVICES

John Piatt

Ten-year-old John Piatt was found wandering the streets of Chicago in the middle of the night. John seemed disoriented when questioned by police and told the officers that his mother had tied him to a bedpost and beat him. John's body was covered with bruises and he had a heeling fracture of his arm. John's family had been receiving intact family services from the Department for the prior year, after his mother had been indicated for abusing him one year earlier.

One year prior, John was found to have loop marks, and scabbed over marks on his arms, face, back and front torso. The body chart also revealed that there were bruises of varying ages all over John's arms, face, back, and neck, indicating a pattern of physical abuse over time. John's mother admitted beating him and referred to him generally in negative terms. The investigator determined that it was not necessary to remove John or his brother from the home and worked with the mother to develop a case plan. The investigator instructed the mother to: clean the house, update the children's immunizations, clean the children and their clothes, send John to school daily, and find alternatives to spanking when disciplining the children. The

investigator then referred the mother for parenting classes, indicated the allegations and transferred the case to follow-up for service provision. The intact family service worker learned soon after he was assigned the case that John's mother had failed to attend parenting classes. While servicing the family for a year, the worker tried to talk the mother into cooperating and attending the required parenting classes, but never succeeded. He did not address the risk of further abuse, other than asking John if his mother hit him, which John denied. Instead, the worker focused on finding housing for the family.

Recommendations

These case examples represent errors of child welfare professionals and with the functioning of the child welfare system itself. Investigators and service providers have enormous jobs and work under untold pressure. Still, by viewing these cases in the aggregate and examining past errors, we can improve our practice procedures. Case-specific recommendations to the Department have been issued in each of the cases presented and systemic recommendations are summarized in the 2003 report to the Governor and the General Assembly. In this report, we would like to highlight to following recommendations as they pertain to protecting youth from violence.

A. There exists several operating bias and field obstacles evidenced in child protection investigations that can be remedied with better communication and cooperation between State Attorneys, Law enforcement and Child Protection Investigators:

1) Child Protection investigators should obtain warrants in cases when there has been an allegation of physical abuse and the parent obstructs the investigative process by not allowing the investigator to see or talk to the child victim.

2) When physical abuse has been substantiated and the family refuses to cooperate with intact family services the child protection investigator and the intact family workers should present a timely petition to the State's Attorney for filing a petition for a protective order. The Department should document the reasons a protective order is being sought and note if the State's Attorney directs the investigator and worker to obtain more information. If the State's Attorney refuses to file, Child Protection and Intact Family services workers should document the reasons for the refusal. A documentation for screening such as the one used by the Cook County Juvenile Court's State's Attorney's Office could be adapted for statewide use.

3) In domestic violence situations with concurrent jurisdictions between juvenile and domestic violence courts the Child Protection Investigator and Intact Family worker must recognize that cooperation in the criminal case is relevant to whether the caretaker can protect the child in the future. They must transport and link the child and the parent victims to victim assistance services. The Child Protection Investigators will make the parent's affirmative duty to obtain a protective order part of the safety plan and inform the parent that DCFS will provide transportation to the court hearing. If the parent fails to bring the child victim to the hearing the child protection worker will immediately arrange to take protective custody and request that a guardian ad litem (GAL) be appointed to represent the child in the domestic battery case. Child Protection and Intact Family worker should obtain copies of protection orders and assist the family in their safety

plans. The child protection investigation should not be closed until a protective order is realized.

4) Child Protection workers need to obtain underlying arrest reports and have access to other relevant information to assess the patterns of violence in all abuse cases. Presently investigators read the Department protocol as not requiring them to obtain these records if the child victim is over the age of six years. Investigators should confirm the identity of subjects and other adults in the home of the abuse reports to assure correct birth dates and spelling for background law enforcement checks. In addition the Department should always allow Child Protection workers free access to any information in its control relative to the safety of children involved in a child protection investigation.

B. Abuse cases must be recognized as precarious and fraught with risk. Child Protection and Intact Family Workers must not over rely on self-reports of abusive parents. Abuse investigations and Intact Family Services to abusive families cannot be compromised by an overemphasis on quick closure or too narrow a focus. Scene investigations should be thorough and sensitive to signs of relevant safety issues such as domestic violence and substance misuse. Having a socio-ecological understanding of the contexts and interaction of who(s), what, where when, and how of an alleged abusive situation allows more effective problem-solving and risk reduction. Child Protection Investigators and Intact Family workers must include the assistance of relevant extended family members and school staff in assessing and securing a safety net for abused children left in the care of their parents. For example if the child is absent for more than two consecutive school days, the school should call the Child Protection and/or the Intact Family worker.

Preventing Violence Among Youth

Although many key indicators of the prevalence of violence among youth (arrest records, victimization data, and hospital emergency room records) have declined in recent years, confidential self-reports from youth reveal that the proportion of youth who acknowledge having committed serious, potentially lethal acts of physical violence (defined as aggravated assault, robbery, rape and homicide) has remained level since its peak in 1993 (US Department of Health and Human Services, 2001). According to the Surgeon General's report, confidential surveys find that 10-15% of high school seniors report having committed an act of serious violence in recent years. A recent investigation conducted by the OIG found that approximately 330 youth in the Department's care have current involvement in the juvenile justice system in Cook County.

The Department is responsible for the well-being of the children in its care. Regardless of the age of the child, there are a number of steps that the Department can take to ensure the safety of its wards and foster protective factors against violence. These steps may be especially important because juvenile courts do not routinely deal with delinquency below the age of twelve and young offenders are the most likely group from which serious and violent offenders will develop (Loeber & Farrington, 1998). The Department also has a number of wards who are pregnant or parenting and may be at risk for harming their own children (Brown et al., 1998; Zelenko et al., 2001). In this section, we will review a number of cases in which the system either failed to detect key risk factors for violence and/or inappropriately placed youth in settings which failed to address issues of violence. Key themes in these cases involve:

- Necessity of identifying risk factors for potential violence;
- Placing youth at risk of harming others in unsupervised settings;
- Necessity of appreciating explosive mix of placing vulnerable infants with unsupervised teens who are ambivalent about parenting and have poor coping skills;
- Necessity of providing treatment to address the violence or the potential for it.

In our recommendations we will differentiate violence prevention among high-risk youth from violence prevention among parenting teens, however, many of the same issues overlap.

According to all indicators, violence reaches its peak during adolescence. As alluded to above, current research on violence suggests that violence is perpetrated by two different types of offenders: those who show signs of problem behavior early on and persist in their offending behavior after adolescence and those whose offending is limited to adolescence (Moffit, 1993). Research also suggests that violence stems from a complex interaction of individuals with their environment at particular times in their lives (see Hawkins et al., 1998 for a review of predictors of youth violence). Risk factors for violence can emerge within several different domains: individual, family, school, peer groups, and community.

Frequently studied risk factors in each domain are listed below in Table 1.

Table 1. Key Risk Factors for Violence by Domain*

Domain	Type	Risk Factor
Individual	Psychological Conditions	Hyperactivity, Attention Deficit, Impulsivity, Restlessness
		Attitudes and Beliefs
	Behavioral	Aggressiveness
		Early Initiation of Violence/Delinquency
		Other Antisocial Behavior
Family Factors		Parental Criminality
		Child Maltreatment
		Poor Family Management Practices
		Lack of Parent-Child Interactions/Involvement
		Family Bonding
		Family and Marital Conflict
		Separation from Parents and Leaving Home
School		Poor Academic Achievement
		Low Bonding to School
		Truancy and Dropping out of School
Peers		Delinquent Siblings
		Delinquent Peers
		Gang Membership
Community		Poverty
		Community Disorganization
		Availability of Drugs
		Adult Involvement in Crime
		Exposure to Violence
		Exposure to Prejudice

*This table was created from Hawkins et al.'s (1998) review of predictors of violence in adolescence and early adulthood.

A small but important body of literature is also being developed on protective factors for violence. Some protective factors highlighted in the Surgeon General's report (2001) within the individual domain of development include intolerant attitudes toward violence, high IQ, positive social orientation, and perceived sanctions for transgressions. Warm supportive relationships with parents or other adults, parental monitoring and positive parental evaluation of peers have been found to be important protective factors in the family domain. Commitment to school and recognition for involvement in conventional activities have been found to be important protective factors within the school realm. Having friends who engage in conventional behavior is a key protective factor in the peer domain.

Risk factors also have been found to have different effects at different stages of development. In their meta-analysis of longitudinal studies, Lipsey and Derzon (1998), found that strongest predictors of violence and serious delinquency at age 15-25 were general offenses and substance use at ages 6-11. At ages 12-14, however, the strongest predictors were social ties and delinquent peers. Table 2 below is taken from Lipsey and Derzon (1998) findings. Rank 1 represents the strongest of the predictors at each specified age group.

Table 2. Ranked Predictors of Violent or Serious Delinquency at age 25 from Lipsey & Derzon (1998)*

Rank	Predictors at Age 6-11	Predictors at Age 12-14
1	General Offense Substance Use	Weak Social Ties Antisocial Peers
2	Gender (male) Family SES Antisocial Parents	General Offense
3	Aggression Ethnicity	Aggression School Attitude/Performance Psychological Condition Parent-Child Relations Gender (male) Physical Violence
4	Psychological Condition Parent-Child Relations Social Ties Problem Behavior School Attitude/Performance Medical/Physical Conditions IQ Other Family Characteristics	Anti-social Parents Person Crimes Problem Behavior IQ
5	Broken Home Abusive Parents Antisocial Peers	Broken Home Family SES Abusive Parents Other Family Characteristics Substance Use Ethnicity

*See Lipsey & Derzon (1998) for background on how they conducted their meta-analysis and for effects sizes for each of the risk factors presented.

While much research has been done to identify risk factors for violence and their effects at different stages of development, it should be noted that not all youth who experience risk factors or who are exposed to protective factors will be affected by them. Prediction of violence is far from an exact science. However, the research that has been conducted can help identify those youth at highest risk for violence and, most importantly, help shape preventive interventions.

In the public health paradigm, primary prevention refers to interventions aimed at preventing a problem before there are signs of its presence. These types of programs are universal and aimed at the general population. Secondary prevention refers to programs that are geared toward preventing a problem among a subgroup of individuals identified to be at risk for it. Tertiary prevention is aimed at preventing future problems among individuals who have already experienced it. A number of successful strategies have been identified in programs to prevent violence at multiple stages. Table 3 below is adapted from the Surgeon General's report and lists successful and unsuccessful strategies by stage of preventive intervention.

Table 3. Successful and Unsuccessful Strategies By Stage of Preventive Intervention*

Stage	Effective Strategies	Ineffective Strategies
Primary	Skills Training	Peer Counseling, Peer Mediation, Peer Leaders
	Behavioral Monitoring & Reinforcement	Non-promotion to Succeeding Grades
	Behavioral Techniques for the Classroom	
	Building School Capacity	
	Cooperative Learning	
	Youth Development Programs	
Secondary	Parent Training	Gun Buyback Programs
	Home Visitation	Firearm Training
	Compensatory Education	Mandatory Gun Ownership
	Moral Reasoning	Redirecting Youth Behavior
	Social Problem Solving	Shifting Peer Group Norms
	Thinking Skills	
Tertiary	Social Perspective Taking/Role Taking	Boot Camps
	Multi-modal Interventions	Residential Programs
	Behavioral Interventions	Milieu Treatment
	Skills Training	Behavioral Token Programs
	Marital and Family Therapy	Waivers to Adult Court
	Wraparound Services	Social Casework
		Individual Counseling

* This table was adapted from the Surgeon General's Report on Youth Violence (US Department of Health and Human Services, 2001). Refer to chapter 5 of the report for methods on how effective and ineffective strategies were determined.

Although residential programs are listed as an ineffective tertiary treatment strategy in the Surgeon General's report, Lipsey et al. (2000; Lipsey & Wilson, 1998) analysed the recidivism effects of 83 studies on interventions with institutionalized offenders and did find that some strategies produced positive effects. Most of the studies involved interventions in juvenile justice institutions (74), but nine involved residential institutions administered by mental health and private agencies. Strategies with consistent evidence of positive effects involved teaching interpersonal skills and using behavioral techniques in family-style group home settings. Strategies with less consistent evidence of positive effects included behaviorally-oriented techniques, community based groups homes, multiple services strategies. Another explanation for the lack of positive outcomes could be that youth requiring such a structured setting are less amenable to treatment and may be less likely to show improved outcomes.

Typically programs are aimed either at directly reducing violence or at indirectly reducing violence by reducing risk factors for it. A number of programs have been found to be successful at these aims. Successful programs and contacts for these programs are listed in Table 4 below. Programs that are rated as "model" programs employed rigorous experimental designs to evaluate their intervention effects, had significant deterrent effects on violence, delinquency or risk factors for violence or delinquency, and demonstrated replicability and sustainability of effects over time. Programs listed as 'promising" had smaller effects and demonstrated either replicability or sustainability over time.

Table 4. Successful Programs by Prevention Stage, Aim, and Rating*

Stage	Prevention Aim	Rating	Program	Contact
Primary	Violence	Model	Seattle Social Development Project	J. David Hawkins
		Promising	School Transitional Environmental Program (STEP)	Robert Felner
	Risk Factors	Model	Life Skills Training	Gilbert Botvin
			The Midwestern Prevention Project	Mary Ann Pentz
		Promising	Promoting Alternative Thinking Strategies	Mark Greenberg
			I Can Problem Solve	Myrna Shure
			Iowa Strengthening Families Program	Richard Spoth
			Preparing for Drug –Free Years	J. David Hawkins
			Linking the Interests of Families and Teachers	John Reid
			Bullying Prevention Program	Dan Olweus
			Good Behavior Game	Sheppard Kellam
Secondary	Violence	Model	Prenatal & Infancy Home Visitation	David Olds
		Promising	Montreal Longitudinal Study	Richard Tremblay
			Syracuse Family Development Research Program	J. Ronald Lalley
			Perry Preschool Program	David Weikart
			Striving together to Achieve Rewarding Tomorrows	Adele Harrell
	Risk Factors	Promising	Parent Child Development Center Programs	Dale Johnson-Stone
			Parent-Child Interaction Training	Joseph Strayhorn
			Yale Child Welfare Projects	Victoria Seitz
			Families and Schools Together	Karen Bierman
			The Incredible Years Series	C. Webster-Stratton
			Preventive Intervention	Brenna Bry
			The Quantum Opportunities Program	C. Benjamin Lattimore
Tertiary	Violence	Model	Functional Family Therapy	James Alexander
			Multisystemic Therapy	Scott Henggeler
			Multidimensional Foster Care	Patricia Chamberlain
		Promising	Intensive Protective Supervision Project	Kathy Dudley

*This table was adapted from the Surgeon General's Report on Youth Violence (US Department of Heath and Human Services, 2001). Please refer to the report for more details on each of these programs. Also see Milhalic et al (2001) for a listing of promising programs identified by OJJDP's Blueprints for Violence Prevention Project. Two popular programs that were found to be unsuccessful were the Drug Abuse Resistance Education (DARE) program and the Scared Straight program.

Risk factors for violence must also be considered with respect to parenting wards. A recent OIG investigation of seven teen parenting cases and two completed investigations recently submitted to the Director from the Teen Parent Service Network (TPSN), identified seven major areas of concern; one of the primary areas of concern was violence.[10] In this study, the OIG found that violence is a recurring theme in the family and community lives of the TPSN sample wards and those in their immediate circles. For example, three of the young women in the TPSN sample experienced domestic violence and two were violent to other members of their family or community. A nineteen-year-old male in the TPSN sample had a juvenile conviction for sexual violence resulting in placement at an out of state locked facility. He was recently attacked by the mother of his child resulting in 25-30 stitches. The two investigative reports previously sent to the Director also revealed the prevalence of violence. The first involved the rape of a seventeen-year-old ward whose level of developmental disabilities made her especially vulnerable to

[10] Contact OIG for a copy of the report.

exploitation and incapable of raising a child. The second report involved the sexual exploitation of a thirteen-year-old child with aggressive impulses who functioned as a seven-year-old.

Appropriate services for these youth were notably lacking. Henggeler, Schoenwald, Borduin, Rowland and Cunningham's treatment manual, Multisystemic Treatment of Antisocial Behavior in Adolescents (1998), gives clear empirical bases for social-ecological strategies that have the highest probability of leading to desired outcomes for adolescents with violent behaviors. Selected interventions match the cognitive and social developments of the youth, caregiver, and significant change agents in the youth's world. The intensity of the intervention and the link between treatment fidelity and clinic outcomes requires a specially trained cadre of social workers and caseworkers with an organizationally capable and committed agency to provide the interventions.

In cases involving the dual phenomena of family violence and mental illness, a family system psycho-educational model is needed. A study of family preservation programs that included looking at programs geared toward family members with mental illness indicated that using this approach helped reduce relapse, hospitalization and symptoms. The study stated: "...These services educate family members about the etiology of mental illnesses...the structure of the mental health system and the use of medications. Moreover, they include problem solving and communications skills training for working with people who have mental illnesses...and with others within the family system"(Fraser, et al., 1997).

The cases reviewed below offer some insight into the difficult issues presented with violent youth.

Case Examples*

Thomas Mason

Thomas was a 16-year-old ward who was returned to a home of relative foster care placement with his grandparents following two-and-a-half years of out-of-state residential placement. Three months into this placement, the client became increasingly aggressive and non-compliant. Several attempts at providing services to the ward and his foster parents failed. Seven months after his return to Illinois, the ward fatally stabbed both his grandparents.

Thomas' biological parents had a history of drug use and imprisonment. Thomas's case was screened into court on a dependency petition in April 1985 (Thomas was 6) because of his mother's inability to care for him due to her substance abuse. Thomas's father was not involved. Thomas's grandparents were awarded custody in August 1985. In April 1992, his grandparents asked the police to remove Thomas from their custody because of Thomas's escalating behavior problems, which included several school suspensions, shoplifting, and the theft of a bicycle.

Thomas was placed in a series of treatment facilities (8 placements between 5/92 and 3/95). Thomas's behavior while in residential placements continued to be problematic including

* All names have been changed to protect the identity of individuals involved. Cases have been summarized for the sake of brevity but every attempt was made to impart key facts on the case. Full redacted reports on these cases are available from the Office of the Inspector General.

property destruction, aggressive behavior (kicking/hitting others, attempting to stab another patient with a small knife, and threatening to kill staff members in an explosive rage, failure to take prescribed psychotropic medication, and running away. Because of these behaviors, he was moved from residential care into a hospital setting in the fall of 1993.

In March 1994, Thomas's discharge plan indicated an anticipated discharge date of June or July 1994 and a plan for placement in a less restrictive environment closer to his grandparents to assess the readiness for a return home to them.

In preparation for Thomas's discharge, a DCFS targeted case manager assigned to Thomas's case, made referrals from July 1994 through December 1994 to a number of potential transition placements in nearby residential facilities. However, all of the programs explored refused to accept Thomas citing Thomas' history of fire-setting, non-compliance with medication, and need for a more structured setting.

During this time, Thomas's destructive and aggressive behavior continued. In January 1995, Thomas kicked out a door and verbally threatened to kick a pregnant staff member in the stomach.

Thomas was returned to his grandparents' home. During the initial period of March through May 1995, Thomas appeared to be doing well in the transition to his foster care placement. He was attending school, counseling sessions with his therapist and psychiatrist. At the April 1995 ACR, Thomas's progress was assessed as "satisfactory" for the goal of return home to his grandparents. Beginning in June 1995, however, there were indications that Thomas's behavior was deteriorating. In early June 1995, he lost his job at McDonald's for allegedly stealing $30 from the cash register. Also in June, his grandparents began to express concern over Thomas's behavior, specifically that Thomas was not following rules, was not taking his medication, and might be drinking and shop-lifting. Of greatest concern, however, is that in June 1995 Thomas discharged a gun into his mattress in his bedroom. At this time the grandparent expressed concern over their ability to maintain Thomas in their home.

His case manager, treatment providers, and grandparents attended a staffing to discuss Thomas's case and his apparent deterioration. At this meeting, the group drafted a behavioral contract for Thomas which outlined things that Thomas needed to do such as take his medication, not drink alcohol, treatment his grandparents with respect, not verbal abuse or threaten his grandparents, and abide by curfews and others rules in his grandparents house. The group convened again in July, at which point, reports from the grandparents indicated further deterioration in Thomas' behavior. The plan developed at this meeting was to convene an emergency LAN meeting and to have the Department remove Thomas from the grandparents home as soon as possible.

The LAN meeting was never held and Thomas's behavior continued to worsen. In August, Thomas' grandparents reported to their foster care workers' supervisors that Thomas was stealing, arrested for criminal trespassing, not taking his medication, staying out all night, in possession of knives, and threatening and intimidating people. Thomas was also taking the car out without permission, stabbing things, and setting fires. The grandparents continued to express

their need to have Thomas removed from their home. His therapist also expressed concern directly to his DCFS case manager in writing that Thomas was in imminent risk of harming his grandparents or himself and needed to be removed from the grandparents' home.

In September, Thomas' case was referred to Placement Stabilization Services to order to stabilize the foster care arrangement with his grandparents. After three weeks of placement stabilization services, it was decided that the placement could not be stabilized and that Thomas' case should be referred to the Departments' Screening, Assessment and Support Services (SASS) program for possible hospitalization. After two failed attempts and nine days after the initial referral, a SASS evaluation determined that Thomas was not appropriate for hospitalization and recommended deflection services. An intensive one-month, wrap-around plan was developed to provide services to Thomas and his grandparents. Approximately two weeks after the SASS evaluation, Thomas fatally stabbed both grandparents.

Yolanda Jones/Carmen Green

Carmen Green is 13 year-old female ward who stabbed an 11 year-old female ward, Yolanda Jones who lived with her in the same residential foster home during an argument. Medical staff pronounced Yolanda dead on arrival at the hospital shortly after the incident. Carmen was charged with first-degree murder. Over a year later, the Juvenile Court found that Carmen was not delinquent on the charge because of self-defense.

Yolanda, who had been a Department ward since 1996, was placed in the foster home 10 months prior to her death. Five months after she was placed she began exhibiting disruptive behavior in the home, including several physical altercations with another female foster child. The girl was referred to a counselor for regular sessions in order to address her behavioral problems.

Two months later, Carmen was placed in the home and soon afterwards she and the 11 year-old began engaging in fights. After arriving for a session with scratches on her face from an altercation with the 13 year-old, the 11 year-old told her counselor that the foster mother frequently left the two girls home alone with nothing to do. The counselor relayed the complaints regarding the lack of structure and supervision to the girl's caseworker and asked to arrange a meeting with him. The caseworker declined, stating his belief the girl was stable in the home and that she would be returned home following a scheduled court date one month later.

The 13 year-old girl became a ward of the Department in 1990 after her mother, who had an extensive criminal history as well as numerous indicated abuse reports, was indicated for cuts welts and bruises against her daughter. During her involvement with the Department, the girl moved through a number of placements. She had a history of aggressiveness, depression, anxiety and poor academic performance. While testing showed her intellectual functioning was within the low average range, it was believed prevailing emotional issues prevented her from fully utilizing her cognitive abilities. After one of her foster parents witnessed the girl exhibiting sexualized play, she was taken for a medical examination at which time the physician found physical evidence suggesting previous sexual abuse.

The 13 year-old also complained about she and the 11 year-old being left alone for extended periods of time. The girl also stated that their foster mother locked the telephone while

she was away and would not allow them to prepare food. A hotline call was made, but the assigned DCP investigator unfounded the case after visiting the home and speaking with the foster mother. The 13 year-old also repeated her frustrations with the placement to her therapist who shared her concerns regarding the foster home with the girl's caseworker.

The fight between the two girls that resulted in the fatal stabbing allegedly stemmed from an argument over clothing. According to the foster mother, as the dispute escalated, the girls began fighting violently and throwing objects at each other. At some point, the 13 year-old grabbed a knife and stabbed the other girl as the 11 year-old lunged at her. The 13 year-old was charged with first-degree murder and the Public Guardian's office was appointed to represent her. She was found not guilty by reason of self-defense.

John Small

A 17-month old boy died of closed head and cervical injuries caused by blunt force trauma. At the time of his death, there was an open child protection investigation. Immediately after the boy's death, his 8-month old sister was hospitalized with pneumonia and an ear infection, and was diagnosed with failure to thrive. The children's mother was a DCFS ward.

The mother had been involved with DCFS since she was eleven, when her brother was indicated for sexually molesting a younger sister and forcing her to watch. The girl later stated that the brother had molested her as well. When the girl was fourteen, her father was indicated for sexually exploiting her. On two later occasions, both her parents were indicated following incidents of physical violence against her. When she was sixteen years old, she was taken into protective custody.

At the time she became a DCFS ward, the girl had a known history of anger issues, homicidal ideation and diagnoses of borderline personality disorder and post-traumatic stress disorder. She briefly excelled academically when she was in the highly structured environment of an alternative detention program. The DCFS supervisor and caseworker nevertheless placed the girl in a Supervised Independent Living program after a short stay in foster care, and did not pursue options such as group homes, extended family or specialized foster care.

In the girl's first six months in the program, she went through three apartments because of threats of eviction and violations of rules. She had frequent police contact for harboring runaways, and numerous people were in and out of her apartment at all hours, prompting complaints from neighbors and landlords. She was frequently truant from school, was suspended multiple times and earned failing grades

The girl gave birth to a baby boy after having been in the independent living program for fifteen months. Her boyfriend, the baby's father, lived with her in her apartment in violation of program rules, but took on much of the responsibility for the baby's care and the household. The girl was very dependent on the boyfriend, and was inconsistent in her attention to the baby's needs. The girl was involved in a physical altercation when she was six months' pregnant, refused to pay rent, and was combative with case managers. The DCFS worker called the hotline because the degree of the girl's anger made her fear for the baby's safety. The hotline took the report as information only. Around the time of her second anniversary in the program, the girl gave birth to a daughter, four weeks prematurely.

A few months after her daughter was born, her son was stepped on during a fight that occurred between guests in the girl's apartment. Shortly thereafter, the boyfriend was arrested for robbery and incarcerated. After her boyfriend was arrested, the girl showed a significant deterioration in her coping skills. The children were not clean and the girl was observed feeding them sour milk in dirty bottles. The boy was eating his feces and both children's growth had significantly declined. Agency staff emphasized practicalities about cleanliness, attention to the children's needs and pursuit of a job with the girl but did not recognize the signs of major depression or consider the risk posed to the children.

The children's pediatrician was becoming increasingly concerned about their declining weight, late immunizations and filthy state and the pediatrician's nurse contacted program staff. The therapist and the caseworker responded by continuing to talk with the girl about ways to manage her stress during the boyfriend's absence. The pediatrician's nurse again contacted the program staff with concerns about missed appointments, the son's habit of eating feces, the daughter's drastically low weight and the filthy condition of the children.

Although the reporter alleged possible malnourishment, the hotline coded the allegation only for inadequate food and environmental neglect. The investigator then limited the investigation to whether adequate food existed in the home without addressing whether the children were receiving enough of it. Three weeks after the DCP investigation began, the boy died as a result of closed head and cervical injuries caused by blunt trauma. The mother was charged with first-degree murder and later pled guilty to involuntary manslaughter and aggravated battery of a child. Her daughter was hospitalized and diagnosed with failure to thrive and was placed in foster care.

Recommendations

C. There are a number of systemic issues that need to be addressed in order to decrease the possibility that a youth in the Department's care will perpetrate violence. Understanding risk factors for violent trajectories can help the Department develop and implement practices aimed at preventing violence among high-risk youth.

Understanding the scope of the problem & identifying youth at high risk for violence

At this point, it is unclear how many youth in the Department's care have perpetrated serious violence or are at risk for future violence. Without these data it is difficult to plan for the provision of services for youth in need of specialized care. Our closest approximation comes from studies of youth at risk for placement failure. In the fall of 2001, Dr. Boris Astrachan, Emeritus of Psychiatry at UIC reviewed statewide data on psychiatric hospitalizations and care received by wards in order to better understand placement failure with a high-risk group. The highest risk group was determined to be those youth psychiatrically hospitalized 3 or more times in a year. His review found that 13% of the Department's wards (N=152) met this criterion in 2001. Because one of the few options for individuals in care of seriously violent youth is psychiatric hospitalization, it is likely that this figure captures some youth who might have perpetrated violence or be at risk for it. However, the actual number of youth may be even

greater. In order to determine the prevalence of violence perpetrated by youth in the Department's care, we recommend the following.

5) The Department must document how many youth in the Department's care meet the definition of a serious and violent offender as specified in the literature (Loeber & Farrington, 1998) as those youth that have committed homicide, rape, robbery, aggravated battery or assault. Further documentation is also needed on how many youth have risk factors known to be predictive of serious violence. Finally a strategy for routinely collecting these data needs to be developed for determining appropriate treatment options for these youth.

6) The Department needs to develop a training agenda for employees who work with youth to help them better understand risk factors for serious violence. The Department should utilize the evening reporting centers in a training curriculum for employees.

Youth at risk for violence in appropriate settings

7) The Department must identify and make available placements for youth at risk for serious violence that implement strategies known to be successful in preventing violence in home-based and residential settings.

8) The Department must develop a strategy for determining what level of care is required for youth at risk of violence.

Collaborating with Juvenile Justice and mental health services to ensure that youth at risk for violence receive appropriate treatment

9) The Department must develop a multisystemic case management approach involving juvenile justice officials (probation officers) and if appropriate mental health providers so that care for youth is coordinated and collaborative.

10) The Department must develop training materials to educate caregivers on best practice procedures involving violent youth.

Implementing violence prevention efforts

11) The Department must make prevention of violence a priority and develop a violence prevention protocol to be implemented by all caregivers of DCFS wards. Youth under the Department's care can be at risk for violence at any age. Emerging empirical evidence suggest a number of factors that can help protect youth from violent trajectories. Care for youth under the Department's supervision must be guided by this research in order to promote the health and well being of wards. Wards under the age of 18 should not be placed in unsupervised apartment settings. Teen parent wards with a pattern of aggressive behaviors and/or voice ambivalence about their babies should not be placed in unsupervised settings and should receive adoption counseling services.

12) The Department must take a proactive stance and sanction those caregivers and treatment providers who promote or place children at risk for a violent trajectory. Youth with low reading levels should receive the services of computerized learning and tutors. Youth who are truant should be transported to school until an effective home-school behavior management program can be initiated.

13) The Department must provide accountability programs for delinquent youth while offering intensive intervention and programming for aggression reduction. Development of an afternoon-evening reporting center would allow alternative to filing juvenile delinquency petitions and provide more coordinated services with juvenile and adult probation. The length and duration of a youth's attendance at the reporting center can be individualized.

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REDACTED REPORT

This report is being released by the Office of the Inspector General for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names, except those of professional references, are fictitious.

File No: **021095**
Minor: Nellie Paulsen DOB: 10/01; DOD: 2/02
Subject: Child Death

Summary of Complaint
Four-month-old Nellie Paulsen died in February 2002. The Medical Examiner's Office determined that Nellie died from asphyxia due to gagging. The manner of death was homicide. Nellie's 40-year-old father confessed to police that he stuffed a washcloth into Nellie's mouth to stop her from crying. The OIG investigated this child's death because there was a prior DCP investigation involving Nellie within a year of her death. On December 11, 2001, the hotline was contacted alleging burns by abuse to Nellie by her father. The report was unfounded on January 9, 2002.

Investigation
Background
Nellie Paulsen was born in October 2001 weighing 4 pounds, 15 ounces. She died in February 2002 at the age of four months. At the time of her death, she weighed 10 pounds, 8 ounces, placing her in the 5th percentile for weight for her age. She measured 24½ inches long, placing her in the 50th percentile for height for her age. Her hydration and cleanliness were good. Nellie lived at home with her 29-year-old mother, Damara Deahl,[11] and her 40-year-old father, Alec Paulsen. According to Mr. Paulsen, the parents were married in 1995. Nellie was the couple's only child together. The mother had one older child, Jared Deahl (DOB 12/91), who entered DCFS custody in April 1992, and was adopted October 1, 1997, by Ms. Deahl's grandmother.

The Paulsen family lived in a building that is nine stories tall and has over one hundred units. Single people, families with children, and senior citizens live in the building. The Paulsen family resided in a one-room studio apartment. The police report of Nellie's death noted, "East of the bed is a large plastic storage container that is on the seats of two kitchen chairs that are facing each other. The plastic container is a make shift crib, which is filled with foam and contains a baby blanket, baby pillow and a couple of baby toys."

According to Ms. Deahl, Mr. Paulsen was the primary caregiver for Nellie because Ms. Deahl suffered from numerous medical problems. Mr. Paulsen was unemployed. He liked to care for the baby and preferred to stay home.

[11] Ms. Deahl went by two names, Damara Deahl and Damara Paulsen. She will be referred to as Damara Deahl throughout this report.

In February 2002, Mr. Paulsen called 911 saying he found Nellie unresponsive. The Fire Department responded and Nellie was brought by ambulance to the hospital where she was pronounced dead. The father was questioned by police. After giving several explanations for how Nellie may have died, Mr. Paulsen confessed that he put a washcloth in Nellie's mouth to stop her from crying. Mr. Paulsen said that he was tired because he hadn't slept all night. He was also tired, frustrated, and crabby because he and Ms. Deahl did not get out of their small apartment together anymore. Mr. Paulsen explained that Ms. Deahl had left for an appointment with the Department of Rehabilitation Services and he was supposed to feed Nellie. He decided to fix Nellie's hair before he fed her. While he was fixing the top and sides of her hair, Nellie was crying, so he folded a baby washcloth and put it in her mouth. Nellie stopped crying when he put the cloth in her mouth. He then laid Nellie face down on the bed to fix the back of her hair. When he was finished, he took the washcloth out of her mouth and laid her back on the bed while he got himself ready. Nellie started to cry again and he tried to comfort her by talking and singing to her. When this didn't work, he put the washcloth back in her mouth. He got some stuff together in the room and noticed that Nellie had turned over onto her stomach. He went into the bathroom, smoked a cigarette, and dozed off while seated on the toilet. When he came out, Nellie was still on her stomach and wasn't moving. He turned her over, changed her diaper, and realized the washcloth was still in her mouth. He took it out and noticed that Nellie was limp, and he could not feel her breathing. He performed CPR and called 911.

The Medical Examiner's Office determined that Nellie died from asphyxia due to gagging and ruled her death a homicide. At autopsy the medical examiner discovered both internal and external injuries. Evidence of external injury included: a petechial hemorrhage (seen as a spot of blood) in the lower white area of her left eye; redness of the soft palate in the back of her mouth indicating inflammation; a reddish-brown abrasion just below her right knee; and old burn scars on her left chest, left forearm, arm, armpit and left shoulder. Evidence of internal injury included: three healing rib fractures on her right side, six healing rib fractures on her left side, including one rib that was cracked in the front as well as on the side; hemorrhages (internal bruising) on her right back and elbow; and an old contusion in the area of her brain above her right ear.

The father was charged with first-degree murder. He was also indicated by DCFS for death by abuse and bone fractures by abuse.

When the mother was interviewed by DCP in April 2002 (forty-two days after the baby's death), she had not yet buried the baby or had a service for her. Ms. Deahl did not believe her husband hurt the baby and said he would spend hours combing Nellie's hair no matter how much she cried. The mother believed the baby suffered a seizure and that was the reason she died. The mother reported being on a lot of medication and had recently been taking Ativan.[12]

DCP Investigation Prior to Nellie's Death

Two months prior to Nellie's death, December 11, 2001, a report was made to the hotline alleging burns by abuse to 2-month-old Nellie by her father, 40-year-old Alec Paulsen. The investigation was unfounded on January 9, 2002.

According to the hotline report, Nellie was brought to the hospital with blistering burns on the left side of her body. Initially, Damara Deahl contacted the hospital and stated that Nellie was burned while Alec Paulsen was bathing Nellie, and the burns were blistering. The hospital advised the parents to call an ambulance to bring Nellie to the hospital, which they did. The hospital noted that Nellie had first and second degree burns to the left side of her face, left chest, and left side of her trunk, and blistering to her

[12] Ativan is an antianxiety medication used to help reduce anxiety associated with depression. Ms. Deahl had a history of depression.

left arm.[13] The injuries were suspicious due to their location as compared to the parents' explanation for the injuries. The hospital noted that if Nellie burned in bath water, the burn would likely be on her bottom area, not her left side. Mr. Paulsen said that Nellie was moving around as he attempted to bathe her. Nellie was transferred to a children's hospital.

On December 12, 2001, the investigation was assigned to child protection investigator Tammy Feeney. A supervision note in the case record documented a supervisory telephone conference in which Ms. Feeney was instructed by her supervisor to interview the reporter, parents, burn doctor, and child protective services team; notify the police of the report; conduct a LEADS check; and measure the water temperature in the home.[14]

Ms. Feeney's first investigative activity was to check on the condition of the baby who was hospitalized. The hospital social worker said the parents seemed appropriate and concerned about the baby and spent the night with the baby. The doctor of the child protective services team said the baby was in stable condition with first and second-degree (partial thickness) scald burns on her left side. She said the father sought medical care immediately for the infant and the burns appeared consistent with the father's story, but she did not know the temperature of the water.

Ms. Feeney interviewed the father, Alec Paulsen, in person on December 13, 2001, at the family's apartment. Mr. Paulsen stated he was bathing Nellie in the bathroom sink because it was very hot in the apartment and he was trying to cool her off. He was holding Nellie in his left arm. He had his hand and arm supporting her head and back. Water was already in the sink and Nellie was moving around. As he tried to get a better grip on her, his hand accidentally hit the hot water knob and the water came out very hot. He said he immediately removed her from the sink, put some saline on the red area, put some Aquaphor[15] on the area, wrapped her in a cool towel, and got her ready to go to the emergency room. His wife had gone to the store. She arrived home a short time later and they took Nellie to the hospital. The investigator observed the bathroom area and felt the water. She noted that it "felt very hot to the touch" and that "the apartment was extremely hot." The story the father told to the child protection investigator was consistent with the explanation he gave to staff at the hospital.[16]

Ms. Feeney interviewed Damara Deahl in person at the family's apartment. Ms. Deahl said she had gone to the store and was not home when the incident occurred. When she returned, her husband told her the baby had been burned by the hot water and they immediately took the baby to the hospital. She stated that neither she nor her husband would hurt the baby. Ms. Deahl said the heat in the apartment is a complaint for many of the residents and that they were trying to move, but needed help. Ms. Deahl said Nellie had not been to her pediatrician since birth because they didn't have a medical card. She said she had an appointment today to see a public aid worker for a medical card and that the social worker at the hospital said she would help her get one. Ms. Deahl reported having social anxiety disorder and being on Paxil prior to her pregnancy. Her doctor took her off the medication during her pregnancy and had not put her back on. He said she only needed counseling, and she saw him once a month.

Ms. Feeney interviewed a friend and neighbor of the Paulsen family at the family's apartment building. The neighbor said she would be willing to care for the baby if a safety plan was necessary. She also said

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[13] The burns to her left arm were the most serious; they were deep second-degree burns and skin grafts were later applied.

[14] According to the case entry, Ms. Feeney was assigned the investigation because she was already at the children's hospital on another report. The case entry is misdated 12/11/01; the date was 12/12/01.

[15] Aquaphor is an ointment for babies. It can be used on dry skin, diaper rash, and minor burns and abrasions.

[16] According to the doctor from the child protective services team, the father said he bathed the baby in the bathroom sink and accidentally hit the knob. Hot water came on and burned the baby. The father said the water gets very hot.

both parents were good with the baby and she did not see any indications that the baby was being abused or neglected.

Ms. Feeney learned via a check of DCFS's computer system that Ms. Deahl had a prior case open with the Department from April 1992 to November 1998. The case involved Ms. Deahl's son, Jared, who was born in December 1991. Jared entered DCFS custody in April 1992 and was adopted by his maternal great-grandmother in October 1997.

Later that same evening, Ms. Feeney spoke with Ms. Deahl by telephone. Ms. Deahl said that her first child was adopted by her grandmother. She explained that she had the child when she was 17 years old and could not take care of him because he was very sick and in and out of the hospital. Ms. Deahl stated that she wanted her daughter to come home and the hospital said DCFS would not let her go home. She said that the woman upstairs from them also got a burn from the water. Ms. Deahl reported that she was not on any medication and that her husband "receives money because of a back injury."

LEADS checks were conducted on Damara Deahl and Alec Paulsen on. Both were negative for criminal histories in Illinois.

On December 14, 2001, Ms. Deahl informed Ms. Feeney that there was a hearing for the building violation and that she thought someone was tampering with the boiler in her building. Ms. Feeney did not recall getting any further information. She did not speak with the building's management or the Building Department.[17]

On December 17, 2001, Ms. Feeney's supervisor contacted Jared's adoption assistance caseworker who said the case was opened for dependency because the mother was very young and Jared was a sick baby. She said that Ms. Deahl signed specific surrenders to the great-grandmother.

Ms. Feeney interviewed the head of the child protective services team on December 18, 2001, who said she was not worried about Nellie as the burns were consistent with the father's explanation. She said the water temperature needed to be measured, but she still felt okay about the infant.

On December 19, 2001, Ms. Feeney met with her supervisor. The supervisor instructed Ms. Feeney to talk to the police, the hospital social worker, and the doctor about the report; tell the social worker that a plan was ready for the child when she was ready for release if the hospital had not yet made a decision about the burn; follow up on the mother's mental health by contacting her doctor; talk to the adoption worker; and inform the family the Department could assist them with Norman funds if the building they were living in was not appropriate.

On December 20, 2001, Ms. Feeney spoke with the reporter, a nurse at the hospital. She said that the mother called the hospital five minutes before bringing the baby into the emergency room. The parents said the baby was burned by hot water while being bathed by her father, and she contacted the hotline because she did not believe the story. The nurse was informed that the children's hospital's child protection team had examined the infant and determined that the burns were consistent with the explanation.

[17] The OIG contacted the city's building department. After Nellie was burned, the Paulsen's friend and neighbor made a complaint to the building department on December 13, 2001. The complaint was accepted, but promptly closed. The building department enforces a minimum water temperature of 120 degrees Fahrenheit. It does not enforce the maximum water temperature, which is 140 degrees Fahrenheit.

Ten days after the burn incident, Ms. Feeney spoke with the mother and told her that a visit would be made today to measure the water temperature. The mother said okay. An hour later there was no answer at the family's door. In an interview with the OIG, Ms. Feeney said she did not measure the bathroom sink's water temperature during her initial visit to the family's apartment on December 13, 2001, because she did not have a thermometer with her and did not know she was supposed to take one with her. She also was not sure if she had access to a thermometer at the time. Ms. Feeney said that when she got a thermometer, she called Ms. Deahl to say she was coming out that day. She thought it was strange that Ms. Deahl was not there to let her in because she told her she was on her way. She reported this to her supervisor. Ms. Feeney did not know whether the water temperature in the Paulsen apartment was ever measured by anyone (e.g., DCFS, police). Ms. Feeney said that she currently has a thermometer that does not work.[18] Since the Paulsen investigation, she has not needed to measure the water temperature in a child protection investigation.

Ms. Feeney spoke with the police officer investigating the burns on December 21, 2001. He said he went to the home, but did not have anything with which to test the water. He said when he turned on the water, the water splashed out of the spout and he could not keep his hand under the water. He said the doctor said that would be enough to burn the child's skin. According to his police report, which is in the record, a doctor at the hospital said that an infant's skin is more thin and sensitive than an adult's and would likely burn in hot water even if an adult were able to put his hand under the water.[19]

On the evening of December 21, 2001, Ms. Feeney's supervisor went to the family's home to discuss housing. The mother told her she and her husband did not want to move from their home and that they wanted their child back home with them. She said that the supervisor could look at the hot water, but that it was fixed and no longer got hot. The supervisor did not measure the hot water temperature. The supervisor asked Ms. Deahl if she would be willing to work with a follow-up worker for a while to help her with her child. Ms. Deahl said she did not want a worker because last time she had one, her son was taken from her. She said she did not need help. Ms. Deahl said she would make sure her daughter went to the doctor for follow-up. The supervisor gave Ms. Deahl a list of housing referrals. The father told the supervisor that he cares for the child all the time. He bathes, feeds, and changes her. He said the mother really only cares for the baby if he has to go somewhere. Mr. Paulsen said he did not want to move unless someone could find the family an apartment that only cost $500 per month. He said he did not want help from the Department.

Ms. Feeney went on vacation December 22, 2001, and returned to the office on January 2, 2002. Ms. Feeney's supervisor continued to work on the case during Ms. Feeney's absence. On December 22, 2001, the supervisor spoke with the emergency room doctor at the hospital. He said he was not able to assess if the burn was consistent with the explanation and suggested that she talk to the doctor at the children's hospital.

On December 24, 2001, the supervisor spoke with a child protection manager about the case. According to her case entry, the child protection manager said it was okay to release the child to the parents when the doctors were ready. They discussed unfounding the report, but opening it for services.

On December 24, 2001, the supervisor informed the hospital that the baby could be released to the parents and that DCFS was going to offer the family services, but they would have to agree to accept them since

[18] The Inspector General recently was told by DCP managers that there were no batteries for the Department's digital thermometers.

[19] This doctor may have been a resident on rotation in the burn unit. She is no longer with the burn unit and the hospital human resources department had no information about her.

they were not being indicated for abuse or neglect. The supervisor requested a copy of Nellie's medical records.

A supervision note dated December 26, 2001, noted that Ms. Feeney was on vacation. The supervisor wrote that the case would be unfounded and opened for services once the parents agreed. She noted that the Associate Deputy Director for Child Protection wanted the case opened for short-term services and that someone needed to talk to the parents about services and obtain copies of the police and medical reports.

The supervisor interviewed Ms. Deahl's grandmother on December 27, 2001. The grandmother said that Jared was sick as a baby and her granddaughter signed papers so he could live with her, and she could get a medical card for Jared. She said Ms. Deahl saw Jared sometimes. The grandmother did not want DCFS talking to Jared because he was never alone with his mother, and he did not know anything about her problems. The grandmother said Ms. Deahl is slow and does not understand things, but she did not think Ms. Deahl ever hurt the baby.

In a case entry dated January 2, 2002,[20] Ms. Feeney contacted Ms. Deahl's psychiatrist's office and spoke with the doctor's secretary. The secretary said they were unable to send her any information regarding Ms. Deahl. Ms. Deahl had signed a consent for release of information and Ms. Feeney told OIG investigators that she had faxed the consent to the psychiatrist's office. The supervisor said the doctor refused to release the records.[21]

The supervisor spoke with the parents by telephone on January 2, 2002. She informed them that the case would be unfounded. She told them they should make sure they followed through on all of Nellie's medical treatment because they needed to make sure she did not get an infection or bad scar from the burn. She talked to the parents about taking Nellie to the clinic for her regular check-ups. The supervisor told the parents they could have a worker short-term to help them with their housing, parenting, and medical appointments for Nellie, but the parents did not want the Department's help.

On January 3, 2002, the supervisor contacted the clinic and spoke with a nurse who said the mother was supposed to follow up with the doctor and then they could come to the clinic for regular medical treatment for the child. The nurse said she would obtain information from the social worker.[22]

The supervisor contacted the police officer investigating the case. The officer said the case was unfounded as an accidental injury and that he would fax over his report. A copy of the report is in the file. Both parents were interviewed by the police. The father said he was giving Nellie a bath because it was very hot in the apartment and Nellie was running a temperature. He said Ms. Deahl had gone to the store to get a thermometer and some children's medicine, but before she left, she filled the bathroom sink with cool water so he could give her a bath and try to bring her temperature down. Mr. Paulsen said when he went to take Nellie out of the sink, his hand hit the hot water knob and turned the hot water on, splashing Nellie and causing burns to her left arm and left side of her face. Ms. Deahl said the apartment

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[20] This was probably January 3, 2002, because Ms. Feeney took a sick day on January 2 and was not in the office.

[21] The doctor should have released the records as Ms. Deahl had executed a valid consent for release of information. The Division of Child Protection, however, has the power to "secure by subpoena both the attendance and testimony of witnesses and the production of books and papers relevant to such investigation." 20 ILCS 505/21. Failure to comply with an investigative subpoena is a Class B misdemeanor. Since the Mental Health Code requires both a subpoena and a consent for release of this type of mental health information, the Office of the Inspector General was unable to obtain the information with a subpoena alone.

[22] The OIG attempted to get records form the clinic. The clinic did not have any record of Nellie Paulsen attending the clinic.

was hot and Nellie was running a temperature so she decided to give her a bath to try and cool her down. She filled the bathroom sink with water and went to the store to get some children's medicine and a thermometer. When she returned home, Mr. Paulsen was upset and told her what happened. They called the hospital's emergency room to ask what they should do. The police interviews were the only interviews in which the parents mentioned Nellie running a temperature.[23] The police went to the Paulsen's apartment and noted that it felt warm inside. They looked at the bathroom sink and noted it had water in it. They turned on the hot water and noted that it came out very fast and was very hot.

A Child Protective Services consult report dated December 12, 2001, is in the investigative file. According to the report, both parents were on disability[24] and served as the baby's primary caregivers. Their daughter had not seen a doctor since birth because of their difficulty getting a medical card. Both parents and the baby lived in a studio apartment. The parents reported that the building was not suitable for children and did not allow children in the building.[25] The parents suspected high lead exposure and reported that there seemed to be trouble with the heating, as their apartment and the water temperature were very hot. Nellie's burns were partial thickness scald burns to her left shoulder, arm, and lateral chest area involving approximately 7% of her total body surface area. Physical exam showed her to be well nourished with no other signs of abuse or neglect. The team opined that the history provided by the parents was consistent with the injury, indicating that the burns were likely accidental.[26] The team noted that there was no delay in seeking medical care after the incident and both parents corroborated the mechanism of injury. The team noted that there was still concern for Nellie's well-being due to the parents' description of their living conditions, in particular the alleged overheating of the apartment and the exposure to lead. The team recommended a thorough investigation of the apartment and the boiler/heater temperatures. They recommended clarification of the rules regarding children in the building, particularly if there was any risk of lead exposure for the child. The team also noted that there was a lack of medical follow-up in the case that seemed to be due to the parents' inability to obtain medical coverage for the baby. It was recommended that the parents receive information about places they might take the baby for routine immunizations and well-child care. The team concluded that they did not feel there was any risk of harm to the child if she was discharged home to the parents with clear instructions on care and follow-up of the burn.

Ms. Deahl's Prior DCFS Case

The OIG reviewed Ms. Deahl's prior case record. According to the record, Jared entered foster care on April 30, 1992, after his mother left him with his maternal grandmother for over a month without an adequate care plan. Jared had asthma and the hospital was refusing to treat him any longer without Ms. Deahl's consent. Jared was placed with his maternal great-grandparents. Ms. Deahl signed surrenders on January 29, 1993, for Jared to be adopted. Jared was adopted by his maternal great-grandparents on October 1, 1997. Records note two psychiatric admissions for Ms. Deahl. The first admission was in 1989 for depression.[27] The second occurred in August 1991 when 18-year-old Ms. Deahl was five

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[23] Upon arrival at the hospital, Nellie's temperature was 97.8 degrees Fahrenheit. Upon admission to the children's hospital, Nellie's temperature was 37.6 (99.6 degrees Fahrenheit). Both temperatures are considered normal for a child Nellie's age.

[24] Mother reported father received money for a back injury. The CPI, Ms. Feeney, said she knew neither parent worked, but she did not recall if she knew both parents were on disability. She did not know why they were on disability.

[25] The OIG viewed the building and spoke with building management. Children do live in the building.

[26] In the letter, the team wrote, "According to the medical record and our social worker's interview, her father reports that he was giving her a cool bath around 8pm on 12/11/01. She was completely undressed, and he was holding her in his left arm and splashing cool water on her because the apartment was too hot. He says that he bent down and accidentally bumped the hot water knob, and hot water immediately poured out of the faucet onto the baby's arm. Both parents were unsure of what to do and called the ER at the hospital for medical advice."

[27] Records regarding this admission were not a part of the case record.

months pregnant with Jared. Ms. Deahl was diagnosed with Major Depressive Disorder, recurrent, severe with psychotic features and Personality Disorder Not Otherwise Specified. She was hospitalized for two weeks and expressed ambivalence about her pregnancy. In a social history, dated May 28, 1992, Ms. Deahl said she never felt bonded to her son.

OIG Scene Investigation

An OIG investigator conducted a scene investigation and mock demonstration of the burn incident in the Paulsens' apartment. The building is nine stories tall and has 126 units. Single people, families with children, and senior citizens live in the building. The Paulsens lived in a studio apartment. Along one wall was a kitchen sink, stove, and refrigerator. There was a small separate bathroom with a toilet, sink, and shower. The sink bowl measured 18.5 inches long, 13 inches wide, and 9.5 inches deep (from bottom of basin to underside of faucet). There was one faucet and two handles. When facing the sink, the cold-water handle was on the right side, the hot water handle on the left side. The handles pull toward you to turn the water on. The handles are tight, not loose. They were located approximately 1½ inches from the back of the vanity (up against the wall). The building manager reported that the bathroom hardware has not been changed since the Paulsens lived in the apartment.

The OIG investigator measured the bathroom sink water temperature with a standard candy thermometer. The thermometer was placed under the running water until it reached 125° Fahrenheit and stopped rising (approximately 1 minute). The building manager could not recall there being any complaints in the building about the water temperature being too hot. No work orders dealing with water temperature could be found for the Paulsens apartment.

The OIG investigator conducted a mock demonstration of the reported incident in the Paulsens' bathroom using a doll. The investigator held the doll in her left arm and placed the doll in the sink. The investigator moved her hands around in various ways to try to accidentally hit the hot water handle as the father said he did, but found it impossible to do. The handle turned on by pulling it forward and there was not sufficient room behind the handle to knock it on.

Analysis

SCOPE OF THE PROBLEM

Nationally, thousands of children suffer burn-related injuries every year. Children ages 4 and under are at the greatest risk, with an injury rate more than four times that of children ages 5 to 14. (National Safe Kids Campaign, 2003). There are six categories of burn injuries: flame, scald, contact (with hot object), electrical, chemical, and ultraviolet radiation (sun) (McLoughlin & Crawford, 1985). Scald burn injuries (those caused by hot liquids or steam) are the most common type of burn-related injury among young children while flame burns (those caused by direct contact with fire) is more prevalent among older children (National Safe Kids Campaign, 2003). In 2001, an estimated 99,400 children ages 14 and under were treated in hospital emergency rooms for burn-related injuries. Of these injuries, approximately 27,200 were scald burns (National Safe Kids Campaign, 2003).

The peak age for accidental scald burns is between the first and second birthdays, when children acquire mobility without the means to protect themselves. Exploratory behavior is at a peak and items such as coffee cups, teakettles, and pot handles become dangerous (Hobbs, Hanks & Wynne, 1999). Hot tap water accounts for nearly 25% of all scald burns among children and is associated with more deaths and hospitalizations than other hot liquid burns. Tap water burns most often occur in the bathroom and tend to be more severe and cover a larger portion of the body than other scald burns (National Safe Kids Campaign, 2003). Older toddlers may be able to climb into a bath into which scalding hot water has been run (Hobbs, Hanks & Wynne, 1999).

The peak age for abusive burns is also one to two years (Scalzo, 1994). The proportion of children with burns and scalds resulting from abuse is not accurately known, with estimates from 4% to 39% (Hobbs, Hanks & Wynne, 1999). It is suspected that under-diagnosis is the rule, as with abuse in general (Hobbs, Hanks & Wynne, 1999). In Fiscal Year 2002, 1202 children were reported to Illinois DCFS for an allegation of burns by abuse or neglect. Only 187 children (.16%) were indicated as victims: 89 for burns by abuse and 108 for burns by neglect (10 children were indicated for both abuse and neglect) (DCFS Office of Quality Assurance, 2003).

BURN PRESENTATION

Burns are usually classified according to their severity, depending on the number of layers of skin injured. First-degree burns, also called partial thickness burns, are superficial burns with damage being limited to the outer layer of the skin (Procedure 300: Appendix B, Burns Definition). They are characterized by redness, tenderness, and swelling. Sunburn is an example of a first-degree burn (Smith, Benton, Moore & Runyan, 1989). Second-degree burns, also called partial thickness burns, are burns in which the damage extends through the outer layer of skin (epidermis) into the inner layer (dermis). (Procedure 300: Appendix B, Burns Definition). They are characterized by blisters on the skin's surface with increased sensitivity to touch. When severe, these injuries can sometimes require surgery (Smith et al., 1989). Third degree burns, also called full thickness burns, are burns in which both layers of skin are destroyed with damage extending into underlying tissue. (Procedure 300: Appendix B, Burns Definition). The area looks white or charred and is not sensitive to touch or pin prick. These injuries require hospitalization and often require skin grafting. (Smith, et al., 1989). Fourth degree burns, also called full thickness burns, are burns that extend beyond the skin and underlying tissue into bone, joints, and muscles (Procedures 300: Appendix B, Burns Definition). These are the most serious burns.

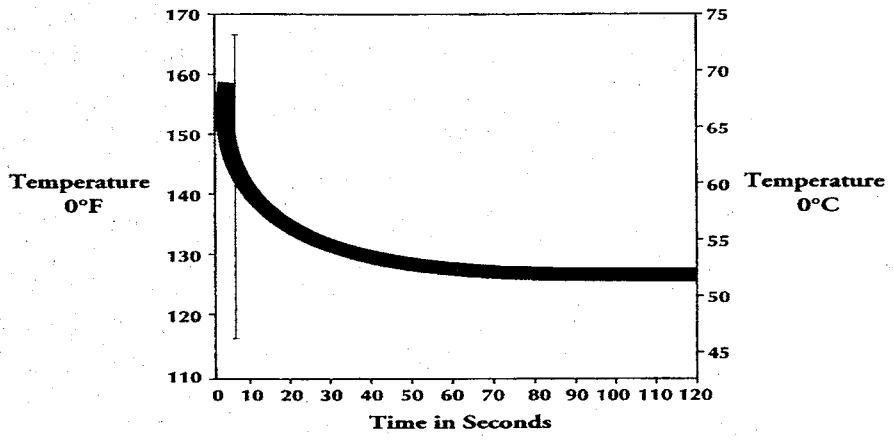
The severity of a burn depends on (1) the thickness of the skin, (2) the temperature of the burning agent, and (3) the length of time of contact with the skin (Jenny, 2001; Jewett & Ellerstein, 1981). Skin thickness varies with age and sex and location of the tissue on the body (Spillert, Vernese & Suval, 1984). Infant skin in many parts of the body is less than half as thick as adult skin (Heimbach, Engrav & Grube, 1992). Skin thickness reaches adult levels by age 5 years. Skin is thickest on the palms and the soles and thinnest on the eyelids and genitals (Jenny, 2001).

Data exist regarding time to cutaneous (relating to the skin) burning as a product of the temperature of water in adults. Water at 44° C (111.2° F), the lowest temperature responsible for cutaneous burning, requires 6 hours to produce a first-degree burn. For each degree Celsius above 44° C and up to 51° C (123.8° F), the time required to produce a burn of given depth decreases by approximately one half. At 49° C (120 F), the lowest setting on most gas water heater thermostats, it takes 5 to 10 minutes to cause full-thickness burns to adult skin. However, at 51°C (124° F) it takes 4 minutes to cause a full-thickness burn. At 52° C (125° F) it takes 2 minutes, and at 54° C (130° F) it takes only 30 seconds to result in a full-thickness scald burn. Water at 60° C (140° F) takes 5 seconds and at 66° C (150° F) takes 2 seconds to produce full-thickness scald burns in an adult (Moritz and Henriques, 1947). At 70° C (158° F), a full-thickness burn will occur in less than 1 second (Robinson & Seward, 1987).

Temperature and duration of exposure sufficient to cause full-thickness burns in ADULTS

120° F (49° C)	5-10 minutes
124° F (51° C)	4 minutes
125° F (52° C)	2 minutes
130° F (54° C)	30 seconds
140° F (60° C)	5 seconds
158° F (70° C)	< 1 second

Time versus temperature graph for skin scalding to occur in ADULTS



(Taken from Scalzo, 1994, adapted from Feldman et al., 1978, based on original work by Moritz & Henriques, 1947).

Infant and children's skin is thinner than adult's skin so serious burning occurs more rapidly and at lower temperatures (Scalzo, 1994). A scald burn in an infant will be more severe than the identical burn inflicted on an adult (Spillert et al., 1984). Very brief exposures to high temperatures can cause serious burns in infants and young children (Jenny, 2001). It has been hypothesized that at temperatures greater than 130° F, children can burn in one-fourth to one-half the time of adults (Feldman, 1983). Infants and children may sustain second and third degree scald burns after exposure to water for 10 seconds at 54.4° C (130° F), 4 seconds at 57° C (135° F), 1 second at 60° C (140° F), and ½ second at 64.9° C (149° F). First-degree scald burns will occur much more quickly (Renz & Sherman, 1992).

Temperature and duration of exposure sufficient to cause partial & full-thickness burns in INFANTS AND YOUNG CHILDREN

130° F (54.4° C)	10 seconds
135° F (57° C)	4 seconds
140° F (60° C)	1 second
149° F (64.9° C)	.5 second

ACCIDENTAL v. ABUSIVE BURNS BY TAP WATER

In the United States, burns from tap water are the most common form of abusive burns (Montrey & Barcia, 1985; Purdue, Hunt & Prescott, 1988). Ninety-five percent of tap-water scalds occur in the home (Baptiste, M.S. & Feck, G., 1980). When children sustain tap water scalds, a very careful examination of the circumstances is required and some kind of abuse or neglect assumed until proved otherwise (Hobbs et al., 1999). Inflicted burns place a child in grave danger of permanent injury or death. Recognition of a

burned child as being abused is the first step in protecting him from further maltreatment (Jewett & Ellerstein, 1981). At the same time, extreme care must be taken to avoid contributing to the emotional trauma of a burned child by incorrectly identifying a parent as abusive (Scalzo, 1994).

Any part of the body may be involved in an abusive burn. The location and extent of the burn (percentage of surface area involved) are not as important as the pattern in determining the probability of abuse (Jewett & Ellerstein, 1981). Some commonalities have been noted in abusive burns. Inflicted scald burns usually involve the lower trunk, buttocks, perineum, and legs. They can also appear as "stocking" or "glove" burns involving the feet and hands. Abusive burns are more likely to have a clear demarcation between burned and normal skin and to have an absence of splash marks (Renz & Sherman, 1993; Renz & Sherman, 1992). Sometimes, the buttocks and soles of the feet will be spared burning if the child's body is pushed down against the cooler surface of the tub or sink. Creases in the child's skin may also be spared, depending on the child's position in the hot water (Lenoski & Hunter, 1977).

In accidental scald burns, the child is less likely to have a clear demarcation between burned and normal skin (Hight, Bakalar & Lloyd, 1979). The burn margins are more likely to be irregular and asymmetric (Yeoh, Nixon, Dickson, et al., 1994). Accidental scald burns are rarely full-thickness burns (Hight, Bakalar & Lloyd, 1979).

There are many historical, clinical, and social clues to the abusive nature of a burn. A thorough history is critical. The most frequently mentioned clue is a discrepancy between the history offered by the child's caregiver and the burn pattern, type, or symmetry (Renz & Sherman, 1992). Other common features of non-accidental burns include the following:

- Delay in seeking medical care
- Presence of other injuries, old and new
- Previous evidence of abuse or neglect (e.g., prior indicated reports)
- History of prior "accidental" injuries
- Malnourished or failure to thrive child
- Caregiver(s) alleges there were no witnesses to the "accident" and the child was merely discovered to be burned
- Scald attributed to action of sibling, other child, or babysitter
- Burn incompatible with developmental age of child
- History provided by caregiver(s) is vague or inconsistent

(Jewett & Ellerstein, 1981; Renz & Sherman, 1992; Scalzo, 1994)

PREVENTION OF ACCIDENTAL SCALD BURNS

Scald burns can be prevented. The most effective means of preventing scald burns is to set the water heater thermostat to 120° F or below. This prevention approach does not depend on the cooperation of children or persons taking care of them (Feldman, Schaller, Feldman, and McMillon, 1978). Other common prevention tips include:

- Install water faucets and showerheads containing anti-scald technology.
- Never leave a child alone, especially in the bathroom or kitchen. If you must leave the room, take the child with you.
- Test bath water before putting a child in it. The correct temperature for infant bath water is between 96.8 and 102.2° F. Many inexpensive products are available to test bath water.
- Put the child in the bath with their back to the faucet so they can't turn the water on.
- Use back burners and turn pot handles to the back of the stove when cooking.

- Keep appliance cords out of children's reach, especially if the appliances contain hot foods or liquids.
- Keep hot foods and liquids away from table and counter edges. Never carry or hold children and hot foods or liquids at the same time.

(National Institute of Occupational Safety and Health, 2003; National Safe Kids Campaign, 2003)

INVESTIGATION OF SUSPECTED BURNS BY ABUSE

The evaluation of burns requires careful attention to historical information, physical examination, and scene investigation (Titus, Baxter & Starling, 2003). A cooperative effort between law enforcement, social services, and medical staff is needed as reliance on a single source for the history or information regarding the injuries can limit the professional's ability to correctly differentiate accidental from suspicious or intentional burns (Scalzo, 1994). All involved should consider the plausibility of the caregiver's description of how the injury occurred given a scene investigation, photographs of the child and the scene of the event, history obtained by several professionals (law enforcement, social workers, nurses, and medical personnel), physical examination, and diagnostic imaging (Scalzo, 1994).

History

The child protection investigator should get a detailed history of the injury from the caregiver, alleged perpetrator, any witnesses, and anyone else having relevant knowledge. The investigator should attempt to answer who, what, where, when, why, and how type questions. Examples of appropriate questions include: what happened, who was involved in the incident, who witnessed it, what caused the injury, what is the child's developmental stage (could the child have done what is alleged), where did the incident occur, and exactly when did the incident occur (if there was a delay in seeking treatment, why) (Smith et al., 1989).

The investigator should work with the caregiver(s) to construct a 24 to 72 hour time line of events leading up to the injury. The timeline should be a general description of activities and behaviors in the days leading up to the injury, a baseline of the family's behavior prior to the change/injury. Questions about the child's routine may be helpful: was the child eating, sleeping, and eliminating normally, was he fussy or crying, what was the caregiver's mood. A timeline can help the investigator learn what stressors or risk factors may have been present prior to the injury.

The investigator should attempt to verify information provided by an interviewee by interviewing other people with knowledge or reviewing available documents. Whenever a discrepancy in information is noted, the investigator should attempt to resolve it.

Physical Examination

A detailed physical examination of the burned child by medical personnel is mandatory. The exam should include not only the burned areas, but a total examination of the child, including diagnostic imaging. If other injuries suggestive of abuse, such as fractures, multiple hematomas, scars, or evidence of growth failure, are present, the probability of abuse increases (Jewett & Ellerstein, 1981; Scalzo, 1994). A history of prior failure-to-thrive, hospitalizations, burns, and accidents in the child being evaluated and in his siblings might elicit a pattern of repeated trauma (Jewett & Ellerstein, 1981).

Scene Investigation

The child protection investigator should conduct a scene investigation. A visit by trained social workers and detectives to the home or scene of the incident can reveal valuable data. This procedure should be requested by medical personnel before final conclusions regarding the etiology of the burn are made (Scalzo, 1994). The environmental circumstances surrounding the incident should be specifically noted. The people, objects, times, and distances should be detailed. For example, in scalds the depth of the

water in the bathtub or other container, the location of the vessel containing the scalding liquid, the temperature of the water, and the chronological sequence of the events before, during, and after the burn should be documented (Jewett & Ellerstein, 1981). Having the caregiver review the events while walking through the area and demonstrating with a doll the child's position, describing the depth of the water, and so on, helps medical personnel to determine whether the injury was accidental (Scalzo, 1994). Injury inconsistent with the history provided by the caregiver is one of the most predictive factors for inflicted injury (Jewett & Ellerstein, 1981; Renz & Sherman, 1992).

Analysis of Information

Analysis of information should be a collaborative effort between social services, law enforcement, and medical staff. Interviews and scene investigations have little usefulness if the information obtained during them is not shared and compared with information obtained by other professionals evaluating the injury. Continued analysis of information can guide the professionals in the next steps of the investigation, as well as help them reach a determination.

THE PAULSEN INVESTIGATION

DCFS Rules and Procedures for the investigation of burns were not followed in the Paulsen case. Moreover, the Rules and Procedures were inadequate to produce a thorough and accurate investigation. Two of the three components for the investigation of burns as described in the literature were neither required nor followed in the Paulsen case: no scene investigation occurred and no diagnostic imaging was conducted on Nellie.

According to DCFS Rules and Procedures, a burn investigation requires "observation of [the] environment where maltreatment occurred" (Appendix B – Procedures 300 Allegation: Burns, Section (c)(2)(E)).[28] Observation of the environment is defined in Section 300.50(j) of Procedures 300, which states that an investigator may observe those specific areas of the home reasonably related to the allegation. The section further states that in a report involving an allegation of burns/scalding, the hot water temperature at the site of the burn/scalding incident shall be measured by the investigator, regardless of whether the alleged perpetrator has admitted to the incident. Thermometers are available through the supervisor and should be taken by the investigator to the initial site/home visit (Procedures 300, Section 300.50(j)).

The child protection investigator, Tammy Feeney, observed the environment where Nellie's maltreatment occurred when she interviewed the parents at home a day and a half after the incident was reported. Ms. Feeney even felt the water in the bathroom sink and noted that it "felt very hot to the touch." However, she did not measure the water temperature and did not take a thermometer with her on this initial visit to the home. Ten days later, Ms. Feeney contacted the mother to tell her she was on her way to measure the water temperature, but when she got to the home, the mother did not answer the door. Later that evening Ms. Feeney's supervisor went to the home to discuss housing issues with the parents. Ms. Deahl told the supervisor the water had been fixed. The supervisor did not measure the water temperature to ensure that it was a safe temperature. Neither Ms. Feeney nor the supervisor interviewed building management to attempt to corroborate the mother's statement that the water temperature had been fixed. In an interview with the OIG, the supervisor stated that she thought she spoke with a police officer who reported the boiler had been fixed. However, this is not recorded in her notes or in the officer's report. The OIG

[28] Observation of the environment is different from scene investigation. Approximately one third of the allegations require the investigator to "document parent/caregiver explanation including scene observation and mock demonstration." The procedures do no provide any instruction on how to do this.

spoke with the building manager who could not recall there ever being a problem with the water in the building being too hot.[29]

The child protective services team should not have given an opinion about Nellie's burns without reviewing a scene investigation and completing a skeletal survey (diagnostic imaging) of Nellie.

In its consult report to DCFS, the child protective services team opined:

> The history provided is consistent with the injury, indicating that this was likely an accidental scald burn. There was no delay in seeking medical care after the incident, and the parents both corroborate the mechanism of injury.[30]

The head of the child protective services team knew that evaluation of Nellie's burns required a scene investigation (including measurement of the water temperature) and diagnostic imaging. The head of the child protective services team provides second opinions for DCFS in abuse cases and in presentations to DCFS staff advocates forensic interviewing and scene investigation in suspected abuse cases. Yet, in this case she did not insist that forensic standards of scene investigation, including water temperature measurement, were met before giving her opinion. She did ask Ms. Feeney to measure the water temperature and knew that Ms. Feeney was supposed to do this. She stated in an interview with OIG staff that she should have insisted on measurement of the water temperature, but did not because she did not think she would get it.[31] She also faulted herself for not doing a skeletal survey on Nellie, which may have revealed the rib fractures discovered after Nellie's death.[32]

The head of the child protective services team felt comfortable giving an opinion that the burns were accidental based on what she knew: the pattern of the burn, the history given, consistency between the parents in the history, and the parents seeking immediate medical attention – all features of accidental burns.

Measurement of the water temperature in a burn investigation is important to determine whether a child could have been burned in the manner described by the caregiver. In this case, instead of measuring the water temperature, DCP, the police, and hospital doctors relied on reports by the parents, the child protection investigator, and police that the water came out of the faucet very hot. Yet, adults find water to be uncomfortable at temperatures around 109° F, while temperatures must be above 120° F to cause full thickness burns in a short amount of time in infants (Smith et al., 1989). Furthermore, while everyone thought the water was hot enough to burn Nellie, no one did anything to ensure that the water temperature was lowered so that it would not burn her again or burn other children or senior citizens in the building.[33]

The OIG's scene investigation of the Paulsens' apartment revealed that the water temperature in the bathroom sink measured 125° F. An adult would suffer a full-thickness burn after 2 minutes in water measuring 125° F. A child would suffer a partial- to full-thickness burn after 10 seconds in water

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[29] After Nellie was burned, the Paulsens' friend and neighbor made a complaint to the city's building department. The complaint was accepted, but promptly closed. The building department enforces a minimum water temperature of 120° F. It does not enforce the maximum water temperature, which is 140° F.

[30] The letter was signed by the doctor for the Child Protective Services; the head of the child protective services team; and a Primary Social Worker.

[31] The head of the child protective services team reported that in prior experiences with DCFS she has had difficulty getting records, x-rays, and other information she needs.

[32] The rib fractures would have had to be caused at least two weeks prior to her burn admission for them to show up on a skeletal survey. It is unknown when the rib fractures were inflicted.

[33] According to medical records, the supervisor told the hospital social worker that DCFS would give the family a baby bath and the parents had been instructed not to bathe Nellie with any running water.

measuring 130° F. Because Nellie was only two months old, her skin was very thin, and it is conceivable that she could suffer partial-thickness burns in 125° F water in a short amount of time.

Water temperature measurement is better thought of as a component of a scene investigation. A scene investigation involves observing the scene of the incident and collecting information such as measurements and physical evidence (e.g., an object alleged to have caused an injury) and matching the information against the history provided. A mock demonstration of the incident by the persons involved in the event will help the investigator visually judge whether the incident could have happened as reported. Examination of the scene should occur as soon as possible (preferably within 24 hours of receipt of a report) to minimize any changes, intended or otherwise, to the scene. Photographs of the scene should be taken whenever possible so they can be shared with physicians and others involved in evaluating the injury. When a digital camera is not available, the investigator should diagram the findings.

The OIG conducted a scene investigation in this case and was unable to match the father's explanation for the injury with the physical findings of the scene. The father's history of the injury was that he was holding Nellie in his left arm while bathing her and his hand accidentally hit the hot water knob turning on the hot water and burning Nellie. The OIG's scene investigation revealed that the water handles turned toward the person standing at the sink. The investigator held the doll in her left arm and tried to hit the hot water handle on with both her left and right hand. She could not turn the hot water on in this manner. An attempt to turn the hot water on while holding the doll in her right arm was also unsuccessful.

This case illustrates why a scene investigation should be a basic requirement whenever a child is injured. Had DCFS Rules and Procedures been followed and the water temperature measured, doctors may still have opined that Nellie's injuries were caused accidentally. Had a scene investigation been conducted and shared with doctors – including the unlikelihood of accidentally turning on the hot water - they may have been more suspicious about the injury and required further investigation, including a skeletal survey of Nellie, before making a determination.

Following up on investigative leads provided during the Paulsen investigation may have led people involved in the investigation to be more skeptical about the father's explanation for Nellie's injuries. Leads provided during the investigation were not followed up on by the investigator or her supervisor to corroborate or contradict the theory that Nellie's injury was accidental. Two examples can be given. First, Ms. Deahl said that the woman upstairs from them also got burned by the hot water. The investigator could have asked for the woman's name and apartment number and interviewed her. Second, after Ms. Deahl told the DCP supervisor that the water temperature in the building had been fixed, DCP could have verified this with building management.[34]

Despite the fact that the Paulsen investigation was unfounded for burns by abuse, concerns were expressed about this family. Hospital personnel documented their concerns about the child's living conditions and lack of medical care in a letter to DCFS. Risk factors to this child apparent from the investigative file included:

- A serious injury in the first two months of life;

[34] The investigator and supervisor should have been suspicious about this report already; earlier in the day, Ms. Feeney had called Ms. Deahl to say she was on her way to measure the water temperature. Ms. Deahl said okay, but when the investigator got there an hour later, Ms. Deahl did not answer the door. She did not tell Ms. Feeney at that time that the water temperature had been fixed.

- A mentally ill mother (whose complete psychiatric history was unknown, but available);[35]
- A mother who previously gave up a child for adoption and who provided little to no care of Nellie (per the family's own reports);
- No medical care since birth and no medical card;
- Both parents on disability for unknown reasons;
- Worrisome living conditions (two adults and one child in a studio apartment, overheating which is a risk factor for SIDS, and possible lead exposure);
- Inappropriate bedding (the infant was sleeping in a plastic container filled with foam, a baby blanket, baby pillow, and toys- all risk factors for SIDS).

A Child Protection Manager and an Associate Deputy Director wanted the case opened for short-term services. Services were offered to the Paulsens, but they refused them.

DCFS RULES AND PROCEDURES

The OIG noted three problems with DCFS Rules and Procedures regarding water temperature measurement. First, Rules and Procedures state that if the subjects of an investigation refuse to allow the investigator to test the water, the investigator shall document his or her attempt on a SACWIS case note and make a decision to indicate or unfound the allegation based on the available information (Procedures 300, Section 300.50(j)). This section should be changed. Because of the risk of further injury or death in cases in which a child was intentionally abused, burn allegations must be thoroughly investigated (Scalzo, 1994). If a family refuses to allow the investigator to test the water, the investigator can solicit the help of law enforcement, building management, or the city's building department.

Second, Rules and Procedures state that water temperature is accurately measured by placing an approved thermometer under the running water for 90 seconds after the faucet has been on for five minutes. The Office of Child and Family Policy could not find a citation for this information and the OIG was unable to confirm that this is the accurate way to measure water temperature. According to the National Institute of Occupational Safety and Health (2003), water temperature should be measured by turning on the hot water tap, leaving it run for two minutes, and holding an outdoor or candy thermometer in the stream of running water until the temperature stops rising. In an influential study of tap water scalds in children, Dr. Kenneth Feldman measured water temperature at two minutes after turning the water on or when the water temperature stabilized, whichever occurred first (Feldman, 1978).[36]

Third, Section 300.50(j) of Procedures 300 states, "The following index identifies those water temperatures and corresponding exposure times at which scalding will occur."

110° F @ 13 minutes	130° F @ 30 seconds
120° F @ 10 minutes	140° F @ 6 seconds
127° F @ 1 minute	158° F @ 1 second

Again, the Office of Child and Family Policy did not have a citation for this information. The index identified in Rules and Procedures is the time at which *adults* will suffer full-thickness scald burns. Infants and children burn more rapidly and at lower temperatures than adults (Scalzo, 1994).

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[35] Ms. Deahl's prior case record refers to two prior psychiatric hospitalizations. At the time of the DCP investigation, Ms. Deahl was under the care of a psychiatrist who refused to release her records even though Ms. Deahl had executed a valid consent for release. DCP could have issued an administrative subpoena for the records with the consent. This is a practice authorized by 20 ILCS 505/21 and Procedures 300, Section 300.60(h), but rarely, if ever, exercised by the Department. See Footnote 11.

[36] Both of these methods determine maximum hot water temperature. In some cases, it may be important to determine not only how hot the water got, but how fast it got there.

Furthermore, burns do not occur at 110° F. The lowest temperature responsible for cutaneous burning is 111.2° F; water at this temperature takes 6 hours to produce a first-degree burn (Moritz & Henriques, 1947). The information in Rules and Procedures should be corrected.

DCFS MANAGEMENT

Management has a duty to support field investigators by having tools available and in good repair that enable investigators to do their work efficiently and effectively. Recently, the Inspector General was told by DCP managers that there were no batteries for thermometers. By not ensuring that batteries were ordered and available, the managers may have sent a message to staff that measuring water temperature was not a policy that needed to be followed. DCFS should make investigative tool kits available to every investigator and encourage them to carry the kits in their cars so they are readily available when they are in the field. In the Paulsen case, had Ms. Feeney had a thermometer in her car, instead of back at the office, she may have been more likely to measure the water temperature on her first visit to the Paulsens' apartment. In this case, the OIG investigator used a thermometer, a measuring tape, and a doll for demonstration, basic tools for a scene investigation.[37]

CONCLUSION

Whenever a child is injured, a careful examination of the circumstances is required. Injury to children is concerning whether the injury is the result of abuse, neglect, or an accident. Some type of intervention is necessary in all three cases. It may range from prevention education to removal of a child. In all cases, we owe children and families thorough, skilled, and accurate investigations. Such investigations require investigators, their supervisors, and managers to have a basic understanding of the injuries being investigated and possess skills to conduct fact-gathering interviews and scene investigations, and analyze information.

Recommendations

1. Child protection trainings should refocus on objective investigative practices including, but not limited to:

- basics of fact-finding interviews, including who, what, where, when, why, and how of the incident; construction of a 24 to 72 hour time line of events leading up to the incident; and verification of information provided;
- basics of a thorough scene investigation, including documentation of observations and measurements (see video of Sharon O'Connor's presentation on forensic scene investigation) and mock demonstration (reenactment) by caregiver(s) of the incident using appropriate props (such as a lifelike doll) in the environment where the incident occurred; and
- collaborative logical analysis of information (scene investigation, interviews, and physical examination of the child) with medical personnel and law enforcement involved in investigation.

2. Procedures 300, Section 300.50(j) should be amended to correctly reflect the index of water temperatures and corresponding exposure times at which a scald will occur for *infants and children* compared to adults. Investigators should be required to hold the approved thermometer in the stream of hot water until the temperature stops rising and record the amount of time that elapsed from turning on the water until the temperature stopped rising. If a family refuses to allow the investigator to test the water, the investigator should solicit the help of law enforcement (when they are also investigating the incident),

[37] OIG Best Practice staff have been distributing dolls to DCFS and POS teams as part of their Home & Fire Safety training.

or building management or the local building department for access to the hot water heater. These procedures should be cross-referenced with Procedures 300, Appendix B, Burns.

3. Although the Legislature has provided that DCFS investigatory powers include the ability to subpoena documents [20 ILCS 505/21, and DCFS Procedures 300, Section 300.60(h) provide instructions for issuing administrative subpoenas, the practice is seldom used. DCFS should immediately issue a policy directive and/or institute remedial training to address the use of administrative subpoenas during investigations.

4. This report should be used as a training tool for child protection investigations.

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REDACTED REPORT

This report is being released by the Office of the Inspector General for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names, except those of professional references, are fictitious.

File No: **032162**
Subject: **Child Death Investigations Involving Infant Sleep Safety**
Date: **June 2003**

Introduction

The Office of the Inspector General (OIG) receives notification from the State Central Register of all child deaths and serious physical injuries in Illinois where the child was a ward of the Department of Children and Family Services (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 generates a preliminary investigation in which the death report is reviewed and computer databases are searched. When prepared by the field, a chronology of the child's life is reviewed. When further investigation appears warranted, records are impounded or requested and a records review is completed. When additional investigation is necessary, a full investigation, including interviews, is conducted. Reports are issued to the Director when recommendations are made.

During Fiscal years 2002 and 2003, approximately 35 cases were referred to the OIG in which infants[38] fitting the above criteria died in their sleep or after being put to bed.[39] The OIG reviewed 20 of these cases for possible inclusion in this report. Seventeen of the 20 cases contained sufficient Department involvement to warrant further investigation into what the Department might have done to reduce the likelihood of these deaths. In these 17 cases, files were obtained on the infants and their families, and workers were interviewed over the phone to collect important information about the facts of the case and their involvement with the infant. A report was submitted to the Department on one of these cases. (See OIG Report #020771.)

The purpose of this report is to review these 17 infant death cases. In addition to reviewing the facts of these cases and information collected from workers involved in these cases, this report will also review the most recent scientific literature on the topic of SIDS prevention and make recommendations to the

[38] In this report, the term infant refers to a child under one year of age.
[39] Independent investigations were conducted on 5 of the 35 cases.

Department about how it can help increase the safety of infants whose families become involved with the Department.

Review of SIDS and Sleep Safety Literature

According to recent vital statistics (Anderson, 2002), 28,035 infants in the US died in the year 2000. Almost 10% of these infants died from Sudden Infant Death Syndrome (SIDS). Although it is the third leading cause of infant mortality overall, it is the leading cause of death of post-natal infants (infants age 28 days to 11 months).[40]

SIDS is typically defined as the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history (Willinger et al., 1991). Some deaths in which SIDS is initially suspected are later deemed to be caused by sleep-related accidents such as overlaying, trapping, and soft-material suffocation.

An overlay death, also commonly referred to as a "rollover" death, is caused when a baby is rolled over on and suffocated by a person sharing a sleeping surface with the baby. The risk of overlaying is increased when the shared sleep surface is small (e.g., a couch or twin bed), there are multiple people sharing the sleep surface with the infant, or an adult co-sleeping with the infant is under the influence of alcohol or other drugs. Trapping or "wedging" occurs when an infant gets caught between two surfaces or falls into a surface and is not strong enough to get out. Common examples include trapping between a mattress and a wall or between couch cushions. Soft material suffocation can occur when infants are placed facedown on materials (pillows, quilts, blanket, comforters, sheepskins, and porous mattresses) that might obstruct their breathing.[41]

During the past decade, a great deal of research has documented factors that increase the risk of SIDS and other sleep-related deaths. In 1992, the American Academy of Pediatrics (AAP) convened a task force to review common characteristics of SIDS cases. Deputy Chief Cook County Medical Examiner, Mita Kalelkar, MD has presented her work on sleep related deaths in Cook County to the AAP and has created a video for the OIG for use by DCFS entitled "The Hazards and Risk Factors of Co-sleeping and Bed Sharing." In 1992, the task force recommended that infants be placed on their backs to sleep to reduce the risk of SIDS. In 1994, the "Back to Sleep" campaign was launched by the AAP, the SIDS Alliance, and Association of SIDS and Infant Mortality Programs.

Since this campaign was initiated, the number of SIDS deaths has decreased dramatically. Willinger et al. (1998) found that, between 1992 and 1996, the rate of SIDS deaths decreased by 38%. However, SIDS is still the leading cause of death of post-natal infants, and certain segments of the infant population, namely minority infants, are at a disproportionate risk. For instance, African American and Native American infants have rates of SIDS deaths that are two to three times higher than the national average (American Academy of Pediatrics, 2000; Gibson et al., 2000). Studies have also found that African Americans are more likely to place their infants in a prone (stomach) sleeping position (Lesko et al., 1998; Willinger et al., 1998). Poverty, parental inexperience, and lack of social support, factors common to clients serviced by the Department, may also place certain segments of the infant population at risk for SIDS and other sleep-related deaths.

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[40] The leading cause of death for infants is congenital anomalies followed by pre-term/low birth weight. Infants rarely die of SIDS in the neonatal phase (0-27 days) of life.

[41] The risk of dying from these sleep-related death decreases as infants get older and are developmentally able to raise their heads, push up, and roll over.

The next section will review common risk factors for SIDS and sleep related deaths as well as highlight AAP guidelines to reduce the likelihood of these deaths. It pulls heavily from the AAP policy statement issued in March 2000. This document can be obtained directly on the web at http://www.aap.org/policy/re9946.html.

Risk Factors for SIDS and Other Sleep Related Deaths

The exact cause of SIDS is unknown. However, a leading hypothesis is that, for a large proportion of cases, SIDS may reflect a delayed development of the arousal or cardiorespiratory control. According to this hypothesis, when the physiologic conditions of these infants become compromised (i.e., when they are not getting enough oxygen), they may not arouse sufficiently to avoid the fatal noxious insult or condition (American Academy of Pediatrics, 2000).

A number of common factors have been found to be associated with infants who have died from SIDS. Together, these factors are referred to as "risk factors," or factors that increase the risk of SIDS. The following factors have been consistently identified across numerous studies: prone sleeping position, sleeping on a soft surface, maternal smoking during pregnancy, overheating, late or no prenatal care, young maternal age, prematurity and/or low birth weight, and being male (American Academy of Pediatrics, 2000). Many of these risk factors, particularly prone sleeping position and sleeping on a soft surface, coupled with co-sleeping also increase the likelihood of other sleep-related deaths such as overlay, trapping, and soft material suffocation. Table 1 below lists these risk factors. Those factors which are "modifiable," or which can be changed to reduce the risk of SIDS and sleep related deaths, are printed in bold text.

Table 1. Risk Factors for SIDS and Sleep-Related Deaths

Risk Factor	Modifiable?	
Prone Sleeping Position		**X**
Wedged Sleeping Position	**X**	
Sleeping on Soft Materials	**X**	
Overheating	**X**	
Maternal Smoking	**X**	
Lack of Prenatal Care	**X**	
Co-sleeping	**X**	
Parental Misuse of Substances	**X**	
Small/Inappropriate Sleep Surface	**X**	
Multiple Co-sleepers	**X**	
Young Maternal Age		
Prematurity/Low Birth Weight		
Gender*		
Race**		

*Studies have found that males are more likely to die of SIDS than females.

**African American and Native American infants are 2 to 3 times more likely than the national average to die of SIDS.

American Academy of Pediatrics (AAP) Prevention Guidelines and Recommendations

Although scientists are still speculating on the exact cause of SIDS, most agree that steps can be taken to reduce the risk of SIDS and other sleep-related deaths. During the past decade, a variety of strategies have been developed that reduce the risk of SIDS. Many of these strategies target modifiable risk factors. The following ten guidelines were taken directly from the AAP policy statement (American Academy of Pediatrics, 2000, pp. 653-655). The original policy statement can be found at http://www.aap.org/policy/re9946.html.

1) Infants should be placed for sleep in a non-prone position. Supine (wholly on the back) confers the lowest risk and is preferred. However, while side sleeping is not as safe as supine, it also has a significantly lower risk than prone. If the side position is used, caretakers should be advised to bring the dependent arm forward to lessen the likelihood of the infant rolling to the prone position.

2) A crib that conforms to the safety standards of the Consumer Product Safety Commission and the ASTM (formerly the American Society for Testing and Materials) is a desirable sleeping environment for infants. (Although many cradles and bassinets also may provide safe sleeping enclosures, safety standards have not been established for these items.) Sleep surfaces designed for adults often are not free of the aforementioned hazards and may have the additional risk of entrapment between the mattress and the structure of the bed (e.g., the headboard, footboard, side rails, and frame), the wall, or adjacent furniture, as well as between railings in the headboard or footboard (Nakamura et al., 1999).

3) Infants should not be put to sleep on waterbeds, sofas, soft mattresses, or other soft surfaces.

4) Avoid soft materials in the infant's sleeping environment. Soft materials or objects, such as pillows, quilts, comforters, or sheepskins, should not be placed under a sleeping infant. Soft objects, such as pillows, quilts, comforters, sheepskins, stuffed toys, and other gas-trapping objects should be kept out of an infant's sleeping environment. Also, loose bedding, such as blankets and sheets, may be hazardous. If blankets are to be used, they should be tucked in around the crib mattress so the infant's face is less likely to become covered by bedding. One strategy is to make up the bedding so that the infant's feet are able to reach the foot of the crib (feet to foot), with the blankets tucked in around the crib mattress and reaching only the level of the infant's chest. Another strategy is to use sleep clothing with no other covering over the infant.

5) Bed sharing or cosleeping may be hazardous under certain conditions (Scragg et al., 1993; Nakamura et al., 1999; AAP, 1997; Byard, 1998). As an alternative to bed sharing, parents might consider placing the infant's crib near their bed to allow for more convenient breastfeeding and parent contact. If a mother chooses to have her infant sleep in her bed to breastfeed, care should be taken to observe the aforementioned recommendations (nonprone sleep position, avoidance of soft surfaces or loose covers, and avoidance of entrapment by moving the bed away from the wall and other furniture and avoiding beds that present entrapment possibilities). Adults (other than the parents), children, or other siblings should avoid bed sharing with an infant. Parents who choose to bed share with their infant should not smoke or use substances, such as alcohol or drugs that may impair arousal.[*]

6) Overheating should be avoided. The infant should be lightly clothed for sleep, and the bedroom temperature should be kept comfortable for a lightly clothed adult (Flemming et al., 1996). Overbundling should be avoided, and the infant should not feel hot to the touch.

7) A certain amount of tummy time while the infant is awake and observed is recommended for developmental reasons and to help prevent flat spots on the occiput [back of the head]. Positional plagiocephaly [skull deformity] also can be avoided by altering the supine head position during sleep.

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[*] *It should be noted that the US Consumer Product Safety Commission is on record as opposing bed sharing by an infant and an adult, particularly if there is more than 1 adult in the bed. Many cases of infant suffocation have been reported during bed sharing (Drago & Dannenberg, 1999). However, it is recognized that a significant portion of the population practices bed sharing between mother and infant as a strategy to facilitate breastfeeding and that the presence of the father in the bed will be common. It is the consensus of the [AAP] Task Force that there are insufficient data to conclude that bed sharing under carefully controlled conditions is clearly hazardous or clearly safe.*

Techniques for accomplishing this include placing the infant to sleep with the head to one side for a week or so and then changing to the other and periodically changing the orientation of the infant to outside activity (e.g., the door of the room).

8) Although various devices have been developed to maintain sleep position or to reduce the risk of rebreathing, such devices are not recommended, because none have been tested sufficiently to show efficacy or safety (Carolan et al., in press).

9) Electronic respiratory and cardiac monitors are available to detect cardiorespiratory arrest and may be of value for home monitoring of selected infants who are deemed to have extreme cardiorespiratory instability. However, there is no evidence that home monitoring with such monitors decreases the incidence of SIDS. Furthermore, there is no evidence that infants at increased risk of SIDS can be identified by in-hospital respiratory or cardiac monitoring (Malloy & Hoffman, 1996). There are no new data that would lead to a change in the recommendations made in the 1985 statement of the American Academy of Pediatrics on prolonged infantile apnea or the 1986 National Institutes of Health consensus statement on the value of home monitors (AAP, 1985; National Institute of Health Consensus Development, 1987).

10) There is concern that the annual rate of SIDS, which has been decreasing steadily since 1992, now appears to be leveling off, as has the percentage of infants sleeping prone. The national campaign for reducing prone sleeping (Back to Sleep) should continue and be expanded to emphasize the safe characteristics of the sleeping environment, including safe bedding practices, and focus on the portion of the population that continues to place their infants prone. Other potentially modifiable risk factors, such as avoidance of maternal smoking, overheating, and certain forms of bed sharing, should be included as important secondary messages.

Although the AAP does not state that co-sleeping is clearly dangerous or clearly safe, it is important to note that, for the majority of clients serviced by the Department, other risk factors concomitant to co-sleeping may make this practice particularly *unsafe*. For instance, many clients serviced by the Department are poor and, therefore, more likely to have inappropriate bedding (examples of this can be seen in Dr. Kalelkar's video "The Hazards and Risk Factors of Co-sleeping and Bed Sharing"). Teen parents, whose bodies are still growing, require more sleep than adults (Mindell et al., 1999) and may sleep more heavily than adults. Substance misuse also increases risk.

SIDS and Sleep-Related Deaths of Department-Involved Infants

Table 2 summarizes key information pertaining to the 17 cases. Brief summaries of these cases can be found in Appendix A. Although each of these cases involves unique circumstances, many similarities exist. For example, 13 of these infants were not sleeping in a crib and 10 infants were co-sleeping (someone else was sleeping with the infant) at the time of death. Interestingly, most of these infants had cribs. However, very few workers involved with these cases informed the caregivers/mothers about the danger associated with co-sleeping or provided information to the mothers about "Back to Sleep."

Table 2. Summary Statistics of Sleep-Related Deaths (N=17)

	N	%
Cause of Death		
SIDS	6 Cases	35%
Overlay	5 Cases	29%
Trapping/Positional Asphyxia	2 Cases	12%
Soft Material Suffocation	1 Case	6%
Mechanical Asphyxia	1 Case	6%

Other Asphyxia or Suffocation	2 Cases	12%
Died While NOT Sleeping In Crib/Bassinet	13 Cases	81%
Died While Co-Sleeping	10 Cases	59%
Median Age of Infant	3 Months	
Median Age of Mother	24 Years	
Race/Ethnicity of Mother		
African American	14 Cases	82%
Caucasian	2 Cases	12%
Hispanic	1 Case	6%
Avg # of Other Children In Mother's Care	2 Children	
Counties Involved		
Cook	11 Cases	65%
Lake	1 Case	6%
Logan	1 Case	6%
Madison	2 Cases	12%
Marion/Clinton	1 Case	6%
Peoria	1 Case	6%
Department Involvement Prior to Death		
Investigation of A/N to Infant	3 Cases	18%
Investigation of A/N to Sibling	2 Cases	12%
Intact Family Case	7 Cases	41%
Teen Wards	3 Cases	18%
Temporary Custody/Foster Care	1 Case	6%
Voluntary Service	1 Case	6%
Deaths Investigated by the Department	11 Cases	65%
Investigations Leading to Indicated Finding	2 Cases	18%
Cases Currently Open with the Department	8 Cases	47%

Cause of Death

The official cause of death from the medical examiner/coroner was determined to be SIDS from natural causes in 6 of these cases.[42] In many of the SIDS cases, numerous risk factors were present. For instance, in one intact family case where the infant died of SIDS, the infant was placed on a couch and left to watch television with two older brothers (ages 11 and 19) while the mother went to the grocery store. When the mother returned, the oldest brother brought the infant to her concerned that he looked funny and was not breathing. At the time of the infant's death, the mother, her six children, and possibly two others were staying in a one-bedroom apartment. There were no beds for the children and no crib for the infant despite requests made to the caseworker.

Five cases involved accidental overlay.[43] In one overlay case, a parenting teen ward took her infant son and her 2½-year-old daughter by bus to visit their biological father in prison. They arrived after visiting hours ended. Although the mother intended to stay overnight on the streets and visit the father the next morning, a woman whom she met on the bus offered to let the family stay overnight with her. The mother placed her infant to sleep between herself and her daughter in a full-size bed. The infant was found unresponsive the next morning.

[42] SIDS is typically a diagnosis of exclusion, meaning that it is given when no other cause of death can be readily identified. Because it is difficult to distinguish SIDS from suffocation, some deaths attributed to SIDS may actually be deaths by suffocation.

[43] In Cook County, overlay is only specified when the parent admits to overlaying the child or the overlay is witnessed by a third party. Therefore, some deaths attributed to SIDS may actually be caused by overlay.

Six other deaths were determined to be due to asphyxia (suffocation). The facts of the cases suggested that 2 of these deaths involved trapping or positional asphyxia. In one of these cases, an infant was put to sleep in a "pumpkin" seat that was placed on the lower bunk of a set of bunk beds. The infant was not fastened into the seat, which fell over. The infant was found between the wall and the bunk bed. The family was receiving services from a private agency because one of the siblings was being reunited with the family.

Another case involved soft-material suffocation. In this case, the mother's family was receiving intact family services because of the maternal grandmother's use of substances. The infant was found unresponsive while staying in the care of his Godmother after being put face down on an adult bed the night before. According to the coroner's report, the infant was staying with the Godmother "for better living and environment conditions." The worker involved with this case, however, did not know why the infant was staying with the Godmother, and it unclear how long he was there.

Finally, another case involved mechanical asphyxia (accidental strangulation). In this case, an infant in temporary foster care was placed to bed in a crib with a pacifier strung around her neck by a ribbon. The foster mother left the infant in the crib to get the infant's sibling ready for bed. When she returned, the infant was found hanging from the rail of the crib by the ribbon attached to her pacifier.

Demographics
The ages of the infants ranged from less than 1 month to 11 months with the midpoint (median) being 2.5 months. The ages of the mothers ranged from 16 to 35 years with the midpoint (median) being 24 years. Most mothers were African American (N=14), and many mothers were also caring for other children (an average of 2 other children) at the time that these infants died.

Department Involvement
Most cases (11) were serviced in Cook County. The type of Department involvement with the families of these infants varied from 5 investigations of abuse or neglect to 12 open services cases. After the infant died, 11 cases were investigated by the Department. Of these, 2 cases were indicated for death due to neglect. As of the writing of this report, 8 service cases are open with the Department.

Current Departmental Practices
The question of whether the workers involved could have done anything to prevent these deaths hinges upon: 1) whether workers recognized risk factors for sleep-related deaths and 2) what DCFS dictates that workers ought to do about them. In the investigation of this cluster of deaths, the OIG spoke with workers who were involved with these cases. Twenty workers were interviewed (see Table 3): 8 investigators or supervisors of investigators involved with the case prior to the infant's death, 6 intact family workers, 2 investigators or supervisors involved with the case after the infant's death, 3 teen parenting workers, and 1 foster care worker. Appendix B lists responses to worker questions by type of worker (investigators prior to the death, death investigators, intact family workers, and other follow-up workers). Information was also gathered from current Department Rules and Procedures. Unfortunately, the investigation found that many workers lacked knowledge about risk factors for sleep-related death and that little is written to guide workers to ensure that infants have safe sleeping arrangements by ensuring that parents and caregivers are informed about how they can reduce the risk of SIDS and other sleep-related deaths.

Table 3. Interview Respondents (N=20)

	N	%
Investigator Involved Prior to Infant's Death	8 Respondents	40%
Investigator Involved After the Infant's Death	1 Respondents	5%
Supervisor of Involvement Prior to Death	0 Respondents	0%
Supervisor of Involvement After Death	1 Respondents	5%
Intact Family Worker	6 Respondents	30%
Supervisor of Intact Worker	0 Respondents	0%
Follow-up Workers*	4 Respondents	20%

*Of these workers, three had teen parenting cases and one had a case of an infant going in foster care.

Training

Table 4 highlights responses from questions posed to workers about sleep safety issues. As this table shows, only half of the workers (N=10) responded that they had received SIDS prevention training such as the "Back to Sleep" campaign. Currently, the Best Practice Fundamentals Training does not include modules on infant sleep safety or on the assessment of environmental risks such as the lack of a crib or adequate sleeping arrangements, despite recommendations made by the Illinois Child Death Review Teams. However, the current training's emphasis on the importance of making sure that there is a direct relationship between the assessment of safety and risk factors and actual services provided would support inclusion of such materials. (See p.16 in Phase 1 of the Best Practice Fundamentals Trainer's Guide)

While many workers knew basic information about SIDS even without prior training, Table 5 shows that many workers lacked knowledge about key risk factors for SIDS. For example, only 65% of the workers questioned knew that passive smoke inhalation was a risk factor for SIDS. Similarly, only 65% knew that babies were NOT more likely to choke if they were placed on their backs to sleep. Only a little over a third of workers (35%) knew that overheating was a risk factor for SIDS. Alarmingly, 20% believed that a sofa was a safe place for a baby to sleep as long as the baby could not fall off of the sofa.

Table 4. Worker Responses to Sleep Safety Questions

	N	%*
Knew that Infant Had a Crib	13	65%
IF NO CRIB, Instructed Caretaker to Obtain One	2	40%
IF NO CRIB, Attempted to Obtain One	0	0%
Observed the Infant Sleeping During a Visit	8	40%
Had Received SIDS Training	10	50%
Informed the Mother about Risks of Co-Sleeping	9	47%
Informed the Mother about "Back to Sleep"	7	37%

*Percentage refers to the number of responses divided by the number of respondents to which the question was applicable (this may be less than 20 if some questions were not applicable to certain respondents).

Lack of training is likely related to the low number of workers who ensured that infants had cribs and informed their clients about problems associated with co-sleeping and about the "Back to Sleep" campaign. Only 65% of workers questioned knew that the infants who died had cribs, meaning that over a third (35%) either did not know whether the infant had a crib or knew that they did not have one. Less

than half of the workers questioned (47%) informed the mother about the problems associated with co-sleeping and even fewer (37%) informed the mother about the "Back to Sleep" campaign.

Table 5. Worker Responses to SIDS Knowledge Questions

True or False Statement	% Correct
SIDS stands for Sudden Infant Death Syndrome (T).	100%
The risk of SIDS can be reduced by doing certain things (T).	90%
Scientists do not know exactly what causes SIDS (T).	100%
Passive smoke inhalation is a risk factor for SIDS (T).	65%
Placing an infant to sleep on its stomach can prevent SIDS (F).	90%
It is safe for a baby to sleep in bed with other children (F).	95%
Babies are more likely to choke if they are sleeping on their backs (F).	65%
Babies should be placed on a soft mattress or pillows when they sleep (F).	100%
It is good to have stuffed animals & extra blankets in a crib with a baby (F).	100%
Overheating is a risk factor for SIDS (T).	35%
It is necessary to educate other caregivers about sleep safety —not just the primary caretaker (T).	100%
A sofa is a safe place for a baby to sleep as long as the baby can't fall off (F).	80%
A baby is safest when put to sleep in a crib or bassinet (T).	95%

It is important to note, however, that even workers with adequate knowledge failed to take steps to ensure the safety of the infants on their caseload. Thus, while knowledge is an essential first step to recognizing risk factors for sleep-related deaths, workers must also be given resources and clear instructions about how to intervene with families to reduce the risk of such deaths.

Investigations

Currently the only directions given to investigators regarding sleep safety are found in Appendix B of Section 300 for the allegation of Substance Misuse (#15/65) in the Department Rules and Procedures Manual. During the formal phase of the investigation of this allegation, the worker is to do an in-person interview with the parents/caretaker. There is a note that the Child Protection Worker "shall give the parents of an involved infant a copy of 'Back to Sleep' and ensure that the infant has a crib or bassinet with a firm mattress."

Three of the 17 cases involved an initial allegation of substance misuse. In one case, neither the initial investigator nor the intact worker informed the mother of the "Back to Sleep" campaign. In another case, the infant had a crib but there was no mattress in it. Two of these infants died while NOT sleeping in cribs.

Regardless of the type of allegation, investigators are expected to indicate in the Child Endangerment Risk Assessment Protocol (CERAP) when a child's living conditions are hazardous and may cause moderate to severe harm. An infant without a crib is at risk for sleep-related death. Parents of infants who are not provided information about SIDS prevention and the "Back to Sleep" campaign may unknowingly place their infant at risk of severe harm. Investigators need to ensure that all infants in Department involved families have safe cribs and that parents are provided information about SIDS prevention and sleep safety.

Intact Family Services

There are few guidelines addressing what intact family services workers should be addressing with families. Intact family workers are charged with the task of ensuring that children are safe while they

remain at home with their parents. An essential safety measure for infants is for workers to ensure that they have safe sleeping equipment (i.e., cribs). Workers also need to provide detailed instructions on how parents can keep their infants safe while sleeping and deliver the message on *multiple occasions* and in *a variety of formats* (in-person discussions, video tape viewing, demonstrations, and brochure review). Research indicates that probability of supine sleeping (sleeping on the back) increases when the message is delivered multiple times and from multiple sources (Willinger et al., 2000).

Workers also need to ensure that any other caregivers or potential caregivers are provided information about sleep safety. This is especially important for teen parents whose family members or extended family members may be sharing parenting responsibilities. Parents should be encouraged to discuss their infant's safe sleep arrangements with anyone who cares for their child. In fact, some research indicates that infants who are usually placed supine may be at greater risk of SIDS if they are ever placed prone (Mitchell et al., 1999; L'Hoir et al., 1998).

Management and Systemic Support

While child welfare workers are expected to competently and ethically perform their duties, the Department is responsible for creating an environment that supports, fosters, and reinforces good practice. First and foremost, workers need an environment that values child safety. In doing so, management must support the field by providing the necessary tools to exercise good practice. In order to sustain good practice, management must also provide workers with strong direction, supervision and monitoring on an ongoing basis.

Beginning in the fall of 2002, the OIG initiated a Fire and Home Safety Training for workers with parenting wards. This training addressed a variety of safety issues including infant sleep safety and SIDS prevention. Since this past fall, the training has expanded to also include intact-family workers, family-preservation workers, DCP investigators, and supervisors of individuals in these positions.

These trainings have elucidated a number of barriers to ensuring that infants have safe sleeping arrangements. First, workers are concerned that the tasks involved are intrusive and might over-step the bounds of the initial allegation that brought the family to the attention of the Department. Second, almost every worker, regardless of position, feels burdened by the added tasks involved in ensuring that infants have safe sleeping arrangements. This burden is felt with respect to the amount of time they have to devote to a case and the resources that they have available to service a case. Finally, workers are concerned that expanding their responsibilities to cover these tasks will increase their personal liability in the event that something does happen to the infant.

All of these barriers can be overcome by providing workers with the necessary tools (e.g., clear guidelines, training, educational materials for parents, cribs, etc.) and support to ensure environmental safety. While the Department is involved with a family, for whatever reason, it is the Department's duty to attempt to ensure that children in the home are safe.

Recommendations

The deaths of these 17 infants represent tragic events or accidents. While accidents can never be fully prevented, the likelihood of accidents occurring can be reduced. Thirteen of these infants were not sleeping in a crib when they died, although most workers reported that the infants had cribs or bassinets. Very few workers involved with these cases informed the caregivers/mothers about the dangers associated with co-sleeping or provided information to the mothers about "Back to Sleep." Some workers have not received training on the "Back to Sleep" campaign, and many workers, regardless of training, did not know about key risk factors for SIDS.

1. DCFS should reduce environmental risks to children involved with the Department by: (a) amending its contract program plans for private agency intact family programs to require the use of the home safety checklist to reduce environmental risks for children (a similar recommendation was previously made by the East St. Louis Child Death Review Team) and (b) incorporating the home safety checklist into the Child Endangerment and Risk Assessment Protocol (CERAP) process. In DCP investigations involving families with infants, investigators need to inspect the home to ensure that each infant in the home has its own crib or bassinet with a firm mattress. An infant without a crib or bassinet with a firm mattress indicates an unsafe factor on the CERAP[44] that must be addressed by educating the family about sleep safety using brochures, discussion, video and/or demonstration. Further, DCP investigators should help families explore means to obtain a crib and lend the family a crib until the family obtains one on their own. Any time an infant is placed in a home via a CERAP safety plan, the child protection investigator must ensure there is a crib in the home and the caregivers are educated about infant sleep safety.

2. DCFS and private agencies should maintain a supply of portable cribs (e.g., Pack and Plays, estimated cost $59-79) or similar products approved by the Consumer Product Safety Commission to lend to families on an emergency basis until the families obtain their own cribs.

3. This Fall the Department should initiate a safety campaign with its field offices and private agencies providing intact family services to address home safety, including sleep safety. This report, the videotape: "The Hazards and Risk Factors of Co-Sleeping and Bed Sharing," public service safety videos, and other free printed materials should be made available to workers to help them understand the importance of reducing environmental risks.

[44] Safety factor #9, "Caretaker has not, or is unable to meet the child's immediate needs for food, clothing and/or shelter; the child's physical living conditions are hazardous and may cause moderate to severe harm."

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Appendix A
Case Summaries

The case summaries that follow describe deaths of infants who have died either in their sleep or after being put to bed. Many of these cases were initially or ultimately classified as deaths due to SIDS. Other cases involve deaths due to overlay or suffocation. All of these cases represent instances in which the safety of the infants was jeopardized because they either were not sleeping in a crib or were improperly positioned when being put to bed. The names of the children involved in these cases have been redacted.

Maggie Dimitri ***OIG Case #020702*** ***Cook County*** ***SIDS***

Maggie was a 10 month-old infant (12/00-11/01) who was found unresponsive by her mother. Maggie and her mother had been sleeping together on a futon couch. When her mother awoke in the morning Maggie was unresponsive. The mother called 911 and Maggie was taken to the hospital where she was pronounced dead.

At the time of Maggie's death, there was a pending investigation against the mother for neglect and substantial risk of physical injury to Maggie's 3-year-old sibling. The 3-year-old was hospitalized and diagnosed with herpes simplex and viral encephalitis. As a result of the encephalitis, the child lost functioning and required specialized care. She was hospitalized for two months. The hospital contacted the hotline after the mother failed to show up for training on how to provide care for the child at home. During the course of the investigation, the mother completed the training, supportive services were put in place, and the 3-year-old was released from the hospital to her mother's care.

Maggie died approximately 3 weeks later. The medical examiner ruled the cause of death SIDS. The initial allegation of medical neglect was unfounded, and Maggie's death was not investigated by the Department. In a phone interview with an OIG investigator, the child protection investigator said that the infant had a bassinet and that he had seen it in the mother's room. He also stated that he had informed the mother about problems associated with co-sleeping. However, he did not inform the mother about "Back to Sleep" and had never observed the infant sleeping during a visit.

Pierce Unger ***OIG Case #021510*** ***Cook County*** ***SIDS***

Pierce was an 8-month-old infant (9/01-5/02) who was found unresponsive by his 19-year-old brother. Pierce had been placed on the couch at 8:00 a.m. and was left to watch television with two older brothers (19 and 11 years old) while his mother went to the grocery store. At some point after the mother returned, the 19-year-old brother noticed that Pierce looked discolored and was not breathing. He took Pierce to his mother who was in another room, and 911 was called. Paramedics arrived and transported Pierce to the hospital where he was pronounced dead.

There were two prior DCP investigations involving this family. The first, prior to Pierce's birth, was in April 2001 for cuts, welts and bruises by neglect and inadequate supervision. It was alleged that a 3-year-old boy got out of his high chair and crawled out the window onto a second story balcony while his then 18-year-old brother was watching him. The child was not injured and the case was unfounded. A second report was made in September 2001 for inadequate supervision and burns by neglect. A 1½-year-old was burned while his then 10-year-old brother was cooking spaghetti. The mother admitted that she had left the children unsupervised while she went to get belongings from the residence the family moved from a week earlier. The family (mother and 6 children) had just moved into a CHA residence and had no furniture in their apartment. The allegation was indicated and the case was opened for intact family services. A service plan was drafted in January 2002, but the worker was unable to locate the mother for a family conference. The family moved from the CHA residence and stayed on and off with relatives and in a shelter until an apartment was found and secured with Norman Funds in March 2002. The apartment had one bedroom; the mother, her six children, and possibly an adult son and husband were living in the apartment. There were no beds for the children and no crib for Pierce who was 6 months old at the time.

At the time of Pierce's death, the family had still not received beds, despite calls made by them to the caseworker. A request for funds for a bunk bed, crib, and dresser was not made by the caseworker until after Pierce's death. Pierce slept in bed with his parents. The sleeping arrangements of the other siblings (ages 19, 11, 9, 6, 4, 2 at the time) are unknown. Pierce's death was ruled SIDS by the medical examiner. The DCP investigation of Pierce's death was unfounded. Subsequent allegations on the mother were indicated and her children have been in placement since 3/11/03.

Garin Asbury ***OIG Case #020953*** ***Cook County*** ***SIDS***
Garin was a 3-month-old infant (10/01-1/02) who was found unresponsive on his back in his crib when his mother went to check on him. The mother called 911 and did CPR until they arrived. The baby was transported to the hospital and pronounced dead on arrival.

Several months earlier, a hotline call had been made alleging that one of Garin's half-siblings had been hit by their mother's live-in boyfriend, the deceased's father. The allegation was indicated for substantial risk of physical injury and cuts, welts and bruises three days after Garin's death. However, no case was opened.

The investigation of Garin's death was unfounded. The medical examiner ruled the cause of death SIDS. The initial investigator told an OIG investigator during a phone interview that he had seen the baby sleeping in a crib (on his back), but did not inform the mother about problems associated with co-sleeping or about the "Back to Sleep" campaign.

Aaron Georgas ***OIG Case #021509*** ***Logan County*** ***SIDS***
Aaron was a 3½-month-old infant (1/02-5/02) who was found unresponsive by his mother and father after they awoke from a nap. The baby was sleeping on his back between them. Neither reported rolling over on him or that anything got in the way of his breathing.

Two months earlier, the hotline was contacted with an allegation of substantial risk of physical injury to the baby because of an incident of domestic violence by the mother against the father. The mother was arrested and charged with domestic battery. She was put on probation and ordered to take parenting classes. The family lived with the maternal grandmother who was seen as a protective factor for the baby. The report was indicated prior to the baby's death and an intact family case was in the process of being opened.

There were no signs of abuse or neglect on the baby. The coroner ruled the cause of death SIDS. According to the worker who investigated the initial allegation, the infant did have a crib, but she did not speak with the mother about the problems associated with co-sleeping because she had seen the baby sleeping in the crib during a visit. A report was made to SCR for death by neglect, however, it was later unfounded based on the autopsy results. The case was closed with the Department as the family had no other children.

Ben MacLurg ***OIG Case #020697*** ***Peoria County*** ***SIDS***
Ben was a 5-week-old infant (10/01-11/01) who was found unresponsive during a nap. He had been lying on his side on a mattress on the floor with his mother. His mother got up to answer a phone call and, later when she checked on him, found Ben unresponsive on his stomach.

There was a DCP investigation pending at the time of Ben's death for inadequate supervision of him and his two siblings by their mother and father. A neighbor reported that the parents had left their children home alone while they attended a party across the street. The initial worker attempted but failed to speak with the reporter. He spoke with the mother, observed the children, and determined the environment was

safe. Ben died while the investigation was pending. A different investigator completed the investigation and gathered information regarding Ben's death. This investigator informed an OIG investigator that Ben did not have a crib and slept on a mattress on the floor. The pending investigation was ultimately unfounded. The coroner determined that Ben died from SIDS. A subsequent allegation after the death was also unfounded and there is no open case with the Department.

Cailan Sawyer ***OIG Case #031042*** ***Cook County*** ***SIDS***

Cailan was a 3-month-old infant (9/02 – 12/02) who was found face down in his crib (bassinet) by his mother when she went to check on him. The mother reportedly had placed the infant to sleep on his back. Cailan was born in September of 2002 with cocaine in his system. His mother admitted to use and said that she had five children at home and that her last child was born substance-exposed 8 years ago. The initial safety assessment determined that the environment was unsafe for the infant and that the case would be opened and assigned to an intact family services worker to assess the mother for services. The safety plan also stipulated that the mother would be referred to drug treatment.

During the investigation, the mother reported that she smoked cocaine about a week and a half earlier and that was the last time she used since eight years ago. She said she had no prior involvement with the Department. The mother had been living with the baby's father, but he was upset that the baby was born with drugs in its system so she moved in with her mother. Her mother had already been raising her other five children. The child protection investigator observed the grandmother's home and noted that it had the necessary supplies, including a bassinet for the baby. The maternal grandmother reported that she took care of the children, that her daughter was rarely home, and that she used the money she received from Public Aid for drugs. The child protection investigator indicated the case, and it was opened for intact family services.

The case was assigned to a private agency in October. From October to December, the intact family service worker referred the mother to drug treatment, but the mother never attended. The worker also made visits to the family and tried to get additional funds for the family from public aid.

Cailan died in 12/02. He looked healthy at autopsy. The medical examiner ruled his cause of death SIDS. DCFS did not investigate Cailan's death. Although both the investigator and the intact family worker told an OIG investigator that they had spoken with the mother about problems associated with co-sleeping, neither spoke to the mother about the "Back to Sleep" campaign.

Darnell Brewer ***OIG Case #030240*** ***Vermillion County*** ***OVERLAY***
Case Management was in Cook County

Darnell Brewer was a 4-month-old infant (3/02-7/02) who was found unresponsive in bed by his mother. Darnell's mother had taken him and his 2½-year-old sister by bus to visit their biological father in prison. The family missed visiting hours and, because the next bus back to their town did not leave until morning, the family was going to stay on the streets. A woman the mother met on the bus allowed the family to stay overnight in her apartment. The mother and both children fell asleep in a full-size bed. The infant was found unresponsive the next morning.

The 18-year-old mother was a ward of the Department. The Department first became involved with the mother when one of her siblings was born positive for cocaine. She became a ward in 1991. Two weeks prior to Darnell's death, the mother had moved to a new transitional living program. The Department investigated the infant's death. The coroner determined that the cause of death was asphyxia due to overlay, and DCFS's death investigation was unfounded. The case is still open with the Department.

Nathan Semison ***OIG Case #020182*** ***Cook County*** ***OVERLAY***
Nathan was a 1½-month-old infant (6/01-8/01) who was found unresponsive after his mother woke up from napping with him on the sofa. The mother was awakened by the baby's great grandmother who was trying to revive the child. Paramedics were called and performed CPR. Nathan was transported to the hospital where he was pronounced dead. Nathan was born substance-exposed and the Department was in the process of opening an intact family case.

The medical examiner determined that the infant died because of overlaying by his mother, and the manner of death was accidental. The Department initiated a death investigation, and the mother was indicated for neglect. An allegation subsequent to the death was also indicated. The case is open with the Department for foster case services.

Darren Keenan ***OIG Case #020771*** ***Cook County*** ***OVERLAY***
Darren was a 3-month-old infant (9/01-12/01) who was found unresponsive by his mother. The mother and her two children had stayed over at the paternal grandmother's home while visiting the children's father. Darren's paternal grandmother indicated that she came home from work and found the mother asleep in a twin bed with her two children. The mother stated that she put the baby down on his back, and she was on her side next to him. The infant's 2-year-old sister was sleeping at the foot of the bed. Darren was found face up, unresponsive. Paramedics were called and he was taken to the hospital where he was pronounced dead on arrival.

Darren's mother has been a ward of the Department since 1994. At the time of Darren's death, she was living in a foster home and receiving services through a private agency. Darren's cause of death was determined to be asphyxia due to overlay. The manner of death was ruled accidental by the medical examiner. The Department's investigation of the death was unfounded. The mother stated that she was not informed of "Back to Sleep" recommendations and that she kept both of her children in bed with her when she slept because she was afraid of crib death.

Approximately 7 months after Darren's death, in July 2002, the mother's caseworker learned that the mother was approximately 6 months pregnant and due in September. The mother asked for additional funds to prepare for the baby's arrival. The caseworker instructed the mother to price a crib and car seats. Three weeks after the infant was born, the caseworker visited the baby for the first time and gave the mother a check to purchase these items. The caseworker learned that the mother had been sharing a double bed with her two children. The caseworker instructed the mother not to sleep with the baby and to place the baby on its back to sleep. Approximately a week later, an agency nurse contacted the mother by phone to discuss baby safety.

This case was investigated by the OIG and a report was issued to the Director in June 2003.

Aiesha Windahl ***OIG Case #030766*** ***Madison County*** ***OVERLAY***
Aiesha was a 19-week-old infant (10/02-10/02) who was found unresponsive by the mother when the mother awoke on the couch with the infant in her arms. According to the mother, she put Aiesha in her crib after breastfeeding her in the middle of the night, but Aiesha was fussy, so she laid with her on the couch. Aiesha was "swaddled" in a blanket that covered her face and mouth. The couch was of standard size. The mother was 6'3" and weighed 230 pounds. The baby was cradled in the mother's arm. The mother was awakened in the morning by her son who was crying in another room. The mother noticed that Aiesha looked "funny." She started CPR and called 911. The baby was transported to the hospital where she was pronounced dead.

The family had an open intact family case for environmental and medical neglect. The infant had a bassinet, which was placed right next to the couch. According to the intact family worker, she had

spoken with the mother about "Back to Sleep," but did not recall speaking to her about problems associated with co-sleeping. The coroner determined the infant's cause of death was asphyxia by overlay. The manner was accidental. The Department's investigation of Aiesha's death was unfounded, and the case has been closed with DCFS since 4/03.

Yvette Carradine ***OIG Case #030195*** ***Cook County*** ***OVERLAY***
Yvette Carradine was a one-month-old infant (6/02-7/02) who was sleeping in the same bed as her mother and found unresponsive the next morning. According to the mother, she laid down in the evening with her baby to watch television. The baby was placed face-up on a pillow. The mother fell asleep and awoke the next morning to find the baby unresponsive. The mother took the baby into the bathroom where the house manager (the baby and the mother were living in a group home) took the baby, called 911, and started CPR. The infant was taken to the hospital by ambulance where she was pronounced dead.

The mother had two cribs in her room. The mother said that she did not put Yvette in the crib after Yvette fell asleep because she was so tired. Her private agency worker said that she had talked with the mother several times about SIDS and not sleeping with her baby. Her worker at the group home said that she had never seen the baby in bed with the mother. However, on the evening in question, the house manager reported that she had seen the baby and the mother asleep in the bed, but she had never received any training on infant safety, SIDS, or the "Back to Sleep" campaign.

The medical examiner determined the cause of death to be asphyxia caused by overlaying. The manner of death was accidental. The child protection investigation of the infant's death was delayed because the mother was incarcerated on an unrelated outstanding warrant. The investigation was ultimately unfounded. The mother's independent living case has been closed with the Department since 11/02.

Jake Kirkland ***OIG Case #030960*** ***Cook County*** ***TRAPPING***
Jake was a one-month-old infant (11/02-12/02) who was found unresponsive by his mother when she went to check on him after a nap. Jake was put down by his mother for a late morning nap on soft pillows on a small sofa in another room. When his mother checked on him early that evening, he was unresponsive. The mother called 911 and the infant was transported to the hospital. The infant had been dead for hours when his mother called 911.

The mother and infant came to the attention of DCFS when they tested positive for opiates and cocaine when Jake was born. Jake suffered from withdrawal symptoms and had to remain in the hospital for a couple weeks. A nurse and social worker attending him expressed concern that the mother had not visited the baby since she left the hospital and no bonding had taken place between mother and child. The hospital social worker wanted DCFS to take protective custody of the child. The child protection investigator visited the mother at home and saw her three other children. The apartment appeared safe and the children appeared healthy and well cared for. The mother had obtained a few cans of formula from WIC and indicated that she could go and get more once the baby was released to her. She also showed the worker infant clothing, shoes, and other infant care items. She did not have a crib or diapers, but reported that her mother had agreed to provide those things for her. The mother said she was afraid to visit the baby in the hospital because he was born substance-exposed, but that she had called the hospital everyday.

The child protection investigator interviewed the maternal grandmother who reported that she did have access to a crib, but also expressed a number of concerns about the mother's honesty, drug use, and the amount of help the mother required of her to raise her children. The child protection investigator referred the mother for substance abuse treatment and intact family services. An intact family services case was opened, but the infant died prior to a visit by an intact family services worker.

Jake's death was investigated by the Department. The child protection investigator spoke with the police detective who went to the house when the incident occurred. The detective indicated that there was a crib in the apartment, but no mattress. The mother was likely asleep when the infant died. Her surviving children reported that their mother was asleep and that she took a lot of naps during the day. They denied seeing their mother ever take drugs.

The medical examiner ruled that the infant died from asphyxia due to being trapped between the couch pillows. The manner of death was accidental. The Department's investigation was unfounded. The case is currently open with the Department because of an allegation indicated subsequent to the infant's death.

Hayes Kennedy OIG Case #031455 Madison County TRAPPING

Hayes Kennedy was a 5-month-old (9/02-2/03) infant. His mother reported that she put Hayes on the bottom bunk of a bunk bed in his "pumpkin" seat. He was not belted into the seat. The mother left the bedroom and fell asleep on the sofa. She was unable to report how long she was asleep, but when she went to check on Hayes, she found him between the wall and the bunk bed. She reported that she ran upstairs to her neighbors for assistance and to call an ambulance. Hayes was transported to the hospital where he was pronounced dead.

Hayes' death was a B-sequence investigation. His mother had been indicated for physical abuse and charged with aggravated battery for injuries inflicted to her oldest son who was 6 years old at the time. The school reported the abuse when they found bruises on his arms, chest, back, and face from a belt. The mother received two years probation and was ordered to comply with DCFS. The abused child was removed from her care. The mother completed parenting classes, the child was returned home, and the Juvenile court closed the case in December 2002. Her DCFS case remained open with a private agency.

The private agency worker told an OIG investigator that she spoke with the mother about sleep safety issues. The mother had a bassinet for Hayes, but reported that he often slept in a "pumpkin" seat. The mother reported that she never thought about getting a crib for Hayes or any of her other children because they scared her.

The coroner determined that the infant died from asphyxiation. The manner of death was accidental. The Department's investigation of the infant's death was indicated against the mother. The case is currently open with the Department.

Erik Blades OIG Case #030233 Lake County SOFT MATERIAL SUFFOCATION

Erik was a 2-month-old infant (6/02-8/02) who was found unresponsive while staying in the care of his Godmother after being put face down on a bed the night before. The coroner listed the cause of death as asphyxia due to soft material suffocation.

According to the coroner's report, Erik was staying with his Godmother "for better living and environment conditions." A private agency had been servicing the case since 4/02 when it was referred by the Department because the family needed an increased level of intervention because of the maternal grandmother's chronic medical problems and substance use. Erik had a crib at his grandmother's home. The intact family worker did not know why the infant was staying with the Godmother and it is unclear how long he was there. The intact family worker told an OIG investigator that she had observed Erik sleeping on his back in a crib during a visit and that she did not inform the mother about the problems associated with co-sleeping or about the "Back to Sleep" campaign because she, herself, had not received any training. The infant's death was not investigated by the Department, and the case is currently closed.

Cade Hollis ***OIG Case #021270*** ***Cook County*** ***SUFFOCATION***
Cade was a 2-½ week old infant (2/02-3/02) who was found unresponsive in her crib by her mother. The mother and infant were living in a shelter. The initial report indicated that the mother found the baby face down in the crib and not breathing and contacted staff members. When interviewed by DCP, the mother reported that she woke up in the morning and looked in on the infant who was in a crib next to her bed. She said she noticed that Cade's chest was not moving and it looked like she was not breathing. She told the child protection investigator that she tried to give the infant mouth-to-mouth resuscitation. When that didn't work, she went to her neighbor who also tried to revive the baby. They then informed staff who called the paramedics. The child was transported to the hospital where she was pronounced dead on arrival.

At the time of the infant's death, there was a pending child protection investigation on the mother for substantial risk of physical injury to Cade because of the mother's drug use during the ninth month of her pregnancy and past treatment failures. Two of her other children were in the Department's care under a dependency petition and have since been adopted. Neither the mother nor the infant tested positive for substances at the child's birth. Reports from the shelter indicated that the mother was doing well. Cade died the day before the case was to be staffed to determine whether the mother would be eligible for out-patient drug treatment.

A child protection investigator visited the shelter after Cade's death as part of the pending investigation. The investigator did not note anything about the crib or how the child was placed in the crib. She did note, however, that the medical examiner's office conducted an on-site investigation in which the mother confirmed that the child was found face down, although she also said that she had placed the baby in the crib on her back. The report also noted that the mother intimated that the child might have suffocated. The medical examiner ruled the cause of death suffocation. The manner was accidental. There is no open case with the Department.

Tim Enright ***OIG Case #030714*** ***Cook County*** ***SUFFOCATION***
Tim was a 5-month-old infant (4/02-9/02) who was found unresponsive by his mother in the babysitter's bedroom after the mother came back from shopping. Tim was taken to the hospital by ambulance where he was pronounced dead. The child had asthma and the child's great grandmother later reported that the child has stopped breathing on two prior occasions.

Tim's mother became voluntarily involved with the Department after she reportedly went to the hospital and stated that she only wanted her older child (DOB 4/01) because the baby cried all the time. The case was opened for voluntary service provision. At the time the case opened, Tim, his sister, and mother were living on and off with different relatives. At his great grandmother's one-bedroom apartment, Tim slept on the couch, while his mother and sister slept with the grandmother. Tim's mother was referred for parenting classes and stated that she was interested in receiving assistance with school, employment, and childcare. She said that her mother would help her with housing. Tim's mother did not want Tim's father to know that she was receiving services from the Department.

Shortly after the case was opened, Tim and his family left the home of the maternal great-grandmother and could not be located by the caseworker. The worker attempted to contact the family at relatives' homes. The worker was informed of Tim's death when she again contacted the maternal great-grandmother looking for the family.

The medical examiner ruled the cause of death suffocation. The manner was accidental. The infant's death was not investigated by the Department and there is no open case with the Department. According to the worker, the mother "went on" after she learned that the Department could not help her with housing. This worker did not inform the mother about the problems associated with co-sleeping or about

the "Back to Sleep" campaign. The worker had not received training about the "Back to Sleep" campaign.

Rachael Lohan ***OIG Case #020886*** ***Marion/Clinton Counties*** ***STRANGULATION***
Rachael was a 1-year-old (12/00-1/02) who was asphyxiated when the ribbon attached to her pacifier looped around the rail of her crib. The medical examiner determined that Rachael died from strangulation. The manner of death was accidental.

Rachael died while in the care of her maternal aunt. DCFS had placed Rachael and her brother with her aunt just a few weeks earlier after DCFS was awarded temporary custody of them. Rachael's mother had a history with the Department dating back to 1998 when she was indicated for lack of supervision of three of her children. The mother had been indicated for substantial risk of physical injury on 10/5/01 and had been referred to follow-up services when the allegation precipitating protective custody was made.

On the evening in question, the maternal aunt reported that she had put Rachael in her crib, left to get Rachael's brother ready for bed, and came back to see Rachael sitting up in her crib with the ribbon attached to her pacifier around the top horizontal bar of the crib. The ribbon had apparently strangled the child. She took the child out of the crib and called 911.

There were a number of different accounts for how the pacifier came to be around Rachael's neck. The aunt reported that the child came to her with the pacifier around her neck and she let her keep it that way. A child protection investigator who spoke with a police officer reported that it was the aunt who placed the pacifier with a ribbon around the child's neck. Day care providers removed it when she got there, but Rachael was at day care for less than a week and it is unclear what the day care providers did to warn the foster family about the dangers associated with placing a ribbon around the child's neck.

The Department's investigation of the child's death was unfounded. Rachael's sibling is still in foster care.

Appendix B
Interview Responses By Type of Worker

Question	Investigator/Supervisor Prior to Death (N=8)	Investigator/Supervisor After Death (n=2)	Intact Family Worker (N=6)	Other* (N=4)	Question Totals (N=20)
Did the infant have a crib or bassinet?	Yes=6 No =2 DK=0	Yes=0 No =1 DK=1	Yes=4 No =2 DK=0	Yes=3 No =0 DK=1	Yes=13 No =5 DK=2
If no, did you instruct the family to get a crib or bassinet?	Yes=1 No =0 DK=0 MS=1	Yes=0 No =0 DK=0 NA=1 (Whereabouts unknown)	Yes=1 No =0 DK=1	---------	Yes=2 No =0 DK=1 NA=1 MS=1
If no, did you attempt to obtain a crib?	Yes=0 No =2 DK=0	Yes=0 No =0 DK=0 NA=1 (Whereabouts unknown)	Yes=0 No =2 DK=0	---------	Yes=0 No =4 DK=0 NA=1
Had you ever observed the baby sleeping during a visit?	Yes=4 No =4 DK=0	----------	Yes=3 No =2 DK=0 MS=1	Yes=1 No =1 DK=1 NA=1	Yes=8 No =7 DK=1 MS=1 NA=1
Was the baby experiencing any medical problems prior to death?	Yes=1 No =7 DK=0	Yes=0 No =2 DK=0	Yes=2 No =4 DK=0	Yes=0 No =4 DK=0	Yes=3 No =17 DK=0
Did the caretaker use drugs or alcohol?	Yes=5 No =3 DK=0	Yes=1 No =1 DK=0	Yes=0 No =4 DK=1 MB=1	Yes=1 No =3 DK=0	Yes=7 No =11 DK=1 MB=1
Have you received SIDS prevention training such as the "Back to Sleep" campaign?	Yes=4 No =4 DK=0	Yes=2 No =0 DK=0	Yes=2 No =4 DK=0	Yes=2 No =2 DK=0	Yes=10 No =10 DK= 0
Did you inform the mother about problems associated with co-sleeping?	Yes=3 No =5 DK=0	Yes=1 No =1 DK=0	Yes=3 No =3 DK=0	Yes=2 No =1 DK=0 NA=1	Yes= 9 No = 10 DK= 0 NA= 1
Did you inform the mother about "Back to Sleep?"	Yes=2 No =6 DK=0	Yes=1 No =1 DK=0	Yes=3 No =3 DK=0	Yes=1 No =2 DK=0 NA=1	Yes= 7 No =12 DK=0 NA= 1
Average quiz score	10.75	11.5	11	12	11.5

DK= Don't Know, NA= Not Applicable, MS= Missing, MB=Maybe
*Other workers include 3 workers for teen parents and 1 worker for a child going into foster care.