OFFICE OF THE INSPECTOR GENERAL

Illinois Department of Children and Family Services

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

JANUARY 2009

DENISE KANE, PH.D.

Inspector General

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

January 1, 2009

To the Governor and Members of the General Assembly:

The Error Reduction legislation, effective June 2008, launched a concerted training effort by the Office of the Inspector General and the Department. (This effort is reported on in more detail in the "Projects and Initiatives" section of this annual report.) In addition to strengthening investigative skills, the training addresses biases and myths, some stubbornly rooted in the field. I have discussed one of these biases, the "Rule of Optimism" (Gambrill, 2005), in my 2001 and 2002 annual letters, but the tenacity of this bias still holds some investigators in its grip. Dingwal, a British researcher (Gambrill, 1990), found that workers preferred to bridge the chasm between idealism and harsh realities by choosing an optimistic reading of a parent's behavior. A parent's brutality was softened when investigators attributed good or well-meaning intentions to the parent. In other cases, an infant with facial bruises was allowed to remain home with a young parent who had a history of violence and poor impulse control because the worker trusted the parent's report that the infant injured himself. Investigators must accept the reality that some parents' desires for drugs, romantic relationships or personal freedoms may override their duty to protect and care for their child.

Still, child protection cannot act alone. A typical investigation takes thirty days or less. Child protection needs the assistance of pediatricians and family physicians who are involved with the family far longer than thirty days to lower risks of harm to infants and children. If child abuse and neglect are going to be combated, the village providing the safety net must include the child's physician and other professionals, as well as family members who are invested in the well-being of the child.

The Department continues to be impaired by high caseloads in violation of the federal B.H. Consent Decree. This organizational variable needs to be remedied, lest the committed investigators, medical professionals, and the child are left abandoned (*see my letter to the Governor, dated November 18, 2008, immediately following*).

The 2008 Error Reduction trainings brought these issues forward. I thank and am humbled by the General Assembly for providing the opportunity to work with the Director, the Child Death Review Teams and Illinois' child protection professionals to lower incidents of errors.

Respectfully,

Denise Kane, Ph.D.

Inspector General

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November 18, 2008

The Honorable Rod R. Blagojevich
Office of the Governor
207 State House
Springfield, IL 62706-1150

Dear Governor Blagojevich,

Presently I am completing a death investigation of a developmentally disabled twelve-year-old who was allegedly killed by a relative caregiver. The child and his brothers were subjects of previous hotline calls and child protection investigations. The children lived in the Joliet area which is one of the fastest growing metropolitan areas in Illinois and the nation. Joliet is also an area where DCFS' child protection teams are well over the standard established in the settlement of a federal lawsuit (BH Consent Decree). One cannot examine the errors committed in the investigations prior to this vulnerable child's homicide without considering organizational variables such as overwhelming investigative caseloads and supervisory vacancies. Other recent investigations tragically show the combination of these variables as contributing to the risks of children.

Attached to this letter are charts showing investigative caseloads across Illinois that exceed the BH consent decree standards. From Belleville north through Champaign/Urbana, Joliet, Cook County and Rockford investigative teams are overloaded. Yet, within the next few weeks child protection is expected to lay off 71 investigators.

The Department cannot be in the position to further risk the safety and well-being of vulnerable children within these communities because of a critical shortage of investigators and supervisors. Also economic hard times increase the risk of abuse and neglect. The coming together of the organizational variables with the factor of individual errors creates a lethal formula.

I do not envy the heavy burden you carry at this time. Yet, I would be remiss in my duty if I did not bring to your attention the violations of the federal consent decree and the consequences these violations will cost in children's lives.

Respectfully,

Denise Kane, Ph.D.
Inspector General
Illinois Department of Children and Family Services

CC Erwin McEwen, Director
Illinois Department of Children and Family Services

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

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INTRODUCTION

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

INVESTIGATION CATEGORIES

Death and Serious Injury Investigations

The Office of the Inspector General investigates deaths and serious injuries of Illinois children whose families were involved in the child welfare system within the preceding twelve months. The OIG is also a member of Child Death Review Teams around the state. The Inspector General is an *ex officio* member of the Child Death Review Team Executive Council. The OIG receives notification from the Illinois State Central Register (SCR) of all child deaths and serious physical injuries where the child was a ward of DCFS, the family was the subject of an open investigation or service case, or the family was the subject of an investigation or case within the preceding twelve months. The notification of a child death or serious injury generates a preliminary investigation in which the death report and other reports are reviewed and computer databases are searched. When further investigation is warranted, records are impounded, subpoenaed or requested and a review is completed. When necessary, a full investigation, including interviews, is conducted. The Inspector General's Office created and maintains a database of child death statistics and critical information related to child deaths in Illinois. The following chart summarizes the death cases reviewed in FY 08:

FY 08 CHILD DEATH CASES REVIEWED

CHILD DEATHS IN FY 08 MEETING THE CRITERIA FOR REVIEW	99
PRELIMINARY INVESTIGATIONS CONDUCTED	5
INVESTIGATORY REVIEWS OF RECORDS	69
FULL INVESTIGATIONS	13
FULL INVESTIGATIONS PENDING	12

Summaries of death investigations, with a full investigative report submitted to the Director, are included in the Investigations Section of this Report. See page 42 for a summary of all child deaths reviewed by the OIG in FY 08.

General Investigations

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

Child Welfare Employee Licensure Investigations

In 2000, the General Assembly mandated that the Department of Children and Family Services institute a system for licensing child welfare employees. The Child Welfare License permits centralized monitoring of all persons providing direct child welfare services, whether they are employed with the Department or a private

agency. The employee licensing system seeks to maintain accountability, integrity and honesty of those entrusted with the care of vulnerable children and families.

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

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

When a CWEL Investigation is completed, the OIG, as the Department's representative, determines whether the findings of the investigation support 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 deviation from a minimum standard of child welfare practice. Department Rule 412.50 (89 Ill. Reg. 412.50) specifies the grounds for licensure action. When licensure action is appropriate, the licensee is provided an opportunity for a hearing. An Administrative Law Judge presides over the hearing and reports findings and recommendations to the Child Welfare Employee Licensure Board. The CWEL Board makes the final decision regarding licensure action.

In FY 08, 15 cases were referred to the Inspector General's Office for Child Welfare Employee License investigations. In addition, the Inspector General's Office provided technical assistance to the Office of Employee Licensure in 8 cases, and monitored pending criminal or abuse/neglect charges in 6 cases.

FY 08 CWEL Investigation Dispositions

CASES OPENED FOR FULL INVESTIGATION	**15**
LICENSES VOLUNTARILY RELINQUISHED	7
INVESTIGATIONS COMPLETED/NO CHARGES	4
CASES PENDING WITH THE ADMINISTRATIVE HEARINGS UNIT (AHU)	2
PENDING INVESTIGATIONS	2
FY 2007CASES CLOSED IN FY 2008	**7**
AHU DENIED REVOCATION	1
LICENSES VOLUNTARILY RELINQUISHED	3
FINAL REVOCATION	2
AHU RECOMMENDED REVOCATION / PENDING BOARD ACTION	1

Criminal Background Investigations and Law Enforcement Liaison

The Inspector General's Office provides technical assistance to the Department and private agencies in performing and assessing criminal history checks. In FY 08, the Inspector General's Office opened 2,126 cases requesting criminal background information from the Law Enforcement Agencies Data System (LEADS). Each case may involve multiple law enforcement database searches. For the 2,126 cases opened in FY 08, the OIG conducted 8,793 searches for criminal background information. In addition, in the course of an investigation, if evidence indicates that a criminal act may have been committed, the Inspector General may notify the Illinois State Police, or it may investigate the alleged act for administrative action only. The Office of the Inspector General assists enforcement agencies with gathering necessary documents. If law enforcement elects to investigate and requests that the administrative investigation be put on hold, the Office of the Inspector General will retain the case on monitor status. If law enforcement declines to prosecute, the OIG will determine whether further investigation or administrative action is appropriate.

INVESTIGATIVE PROCESS

The Inspector General's Office investigative process begins with a Request for Investigation or notification by the State Central Register of a child's death or serious injury or a complaint. Investigations may also be initiated when the OIG learns of a pending criminal (or child abuse investigation for referral to CWEL) against a child welfare employee. In FY 08, the OIG received 2,474 Requests for Investigation.[1] Requests for Investigation and notices of deaths or serious injury are screened to determine whether the facts suggest possible misconduct by a foster parent, Department employee, or private agency employee, or whether there is a need for systemic change. If an allegation is accepted for investigation, the Inspector General's Office will review records and interview relevant witnesses. The Inspector General reports to the Director of the Department and to the Governor with recommendations for discipline, systemic change, or sanctions against private agencies. The Office of the Inspector General monitors the implementation of accepted recommendations.

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

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

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

Administrative Rules

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

Confidentiality

A complainant to the Office of the Inspector General, or anyone providing information, may request that their identity be kept confidential. To protect the confidentiality of the complainant, the OIG will attempt to procure evidence through other means, whenever possible. The OIG and the Department are mandated to ensure that no one will be retaliated against for making a good faith complaint or providing information in good faith to the OIG. At the same time, an accused employee needs to have sufficient information to enable that employee to present a defense.

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

Impounding

The Office of the Inspector General is charged with investigating misconduct "in a manner

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

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

REPORTS

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

The Office of the Inspector General uses some reports as training tools to provide a venue for an ethical discussion on individual and systemic problems within the practice of child welfare. 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. Redacted OIG reports are available from the Office of the Inspector General by calling (312) 433-3000.

Recommendations

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

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

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

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

In this Annual Report, systemic reform recommendations are organized into a format that allows analysis of recommendations according to the function within the child welfare system that the recommendation is designed to strengthen. The Inspector General's Office is a small office in relation to the child welfare system. Rather than address problems

in isolation, the OIG views its mandate as strengthening the ability of the Department and private agencies to perform their duties.

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

ADDITIONAL RESPONSIBILITIES

Office of the Inspector General Hotline

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

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

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

The following chart summarizes the Office of the Inspector General's response to calls received in FY 08:

CALLS TO THE OIG HOTLINE IN FY 08

INFORMATION AND REFERRAL	1087
REFERRED TO SCR HOTLINE	101
REFERRED FOR OIG INVESTIGATION	147
TOTAL CALLS	1335

Ethics Officer

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

For FY 08, 701 Statements of Economic Interest were submitted to the Ethics Officer. Of the 701 submitted, 73 indicated potential conflicts of interest. The 73 were further reviewed and 20 advisory letters were sent to employees notifying them of steps to take to avoid conflicts of interest between their outside activities and their state employment.

OIG ACTION ON FY 08 STATEMENTS OF ECONOMIC INTEREST

ECONOMIC INTEREST STATEMENTS FILED	701
STATEMENTS INDICATING POSSIBLE CONFLICTS	73
ADVISORY LETTERS SENT TO EMPLOYEES	20

The OIG Ethics staff also coordinated DCFS compliance with the statewide ethics training mandated under the Illinois State Officials and Employees Ethics Act of 2003. In 2008, 3,036 DCFS employees were trained.

Consultation

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

Projects and Initiatives

Informed by the Office of the Inspector General investigations and practice research, the Project Initiatives staff assist the Department's Division on Training and Professional Development in the development of practice training models for caseworkers and supervisors. The model initiatives are interdisciplinary and involve field-testing of strategies. The initiatives are evaluated to ensure the use of evidence-based practice and to determine the effectiveness of the model. See page 145 of this Report for a full discussion of the current projects and initiatives.

INVESTIGATIONS

This annual report covers the time from July 1, 2007 to June 30, 2008. The Investigations section has three parts. Part I includes summaries of child death and serious injury investigations reported to the Department Director and the Governor. Part II contains aggregate data and case summaries of child deaths in families who were involved with the Department in the preceding 12 months. Part III contains general investigation summaries conducted in response to complaints filed by the state and local judiciary, foster parents, biological parents and the general public.

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

DEATH AND SERIOUS INJURY INVESTIGATIONS

DEATH AND SERIOUS INJURY INVESTIGATION 1

ALLEGATION

A four and a half month-old girl died as a result of physical abuse inflicted by her mother's boyfriend. A child protection investigation of prior abuse of the girl was pending at the time of her death.

INVESTIGATION

The girl was brought to a hospital emergency room three months after her birth by her maternal grandmother and step-grandfather with a bruise to the side of her face and a human bite mark on her shoulder. Both expressed concerns the baby was being abused by her mother's boyfriend. The grandparents were instructed by hospital staff to keep the baby in their custody until they were contacted by the Department. The assigned child protection investigator began her work on the case by going to the home of the baby's maternal aunt, which was listed in the report as the family's address. The aunt stated that neither the mother, grandmother nor the baby were present, and she was unable to provide any other information regarding their whereabouts. Soon afterwards the investigator was contacted by the 17 year-old mother who provided her with two additional addresses, identifying one as her own residence and the other as the grandmother's home. The mother alleged both grandparents were involved with drugs and that their house was in a state of disrepair.

After returning to her office the investigator was met at the facility by the grandmother with the baby. The investigator observed the injuries and recorded in her notes that the bite mark appeared to have come from a child, though she had no professional basis for reaching that conclusion. The grandmother reported the baby had previously been treated for a facial injury sustained when she banged her head against a crib. The grandmother confirmed her home was unfit for a child and said the grandfather had a history of substance abuse but had recently completed a rehabilitation program. The investigator was already aware the grandfather had been indicated for physical abuse of the mother when she was 15. At the conclusion of their meeting, the investigator directed the grandmother to return the baby to her mother. The grandmother stated she would return the child the following day. The investigator then completed a Child Endangerment Risk Assessment Protocol (CERAP) determining the baby to be safe and recommending a referral for intact family services. In doing so, the investigator failed to consider numerous factors contributing to the baby being in an unsafe environment: the grandparents' substance abuse issues and inadequate housing, the presence of prior

bruising to an infant, the grandfather's previous abuse of the mother and a dubious explanation for a prior injury to the child that required medical attention. The investigator had also not observed the home of the mother where the baby would reside after being returned or make any attempt to contact the mother's boyfriend.

The following day, the mother arrived at the Department field office stating the grandmother had refused to return the child. The investigator wrote a letter to police informing them the Department was advocating the baby's return to her mother and enlisting their assistance. In separate interviews with the OIG, both the investigator and her supervisor stated that they continued to pursue a referral for intact family services because this was an "A" sequence report, the first involving the family. At no time did the investigator or her supervisor consider taking the baby into protective custody until they were able to properly assess the overall family situation. An OIG review of field office records from the time period show staff had a high volume of cases and the investigator was above B.H. levels.

Two months after the report was made, and while the investigation was still pending, the baby was transported to a hospital emergency room unconscious and not breathing. Attending physicians observed brain swelling, retinal hemorrhaging, a broken clavicle, fractured ribs and bruising. Two days after being admitted to the hospital, the baby died. The mother's boyfriend was charged with murder and aggravated battery to a child. He is currently awaiting trial.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be disciplined for failure to appropriately investigate the allegation of cuts, bruises and welts to the baby and properly assess her safety. The contextual circumstances of the office should be considered in imposing discipline.

The child protection investigator resigned.

2. The child protection investigator's supervisor should be disciplined for failure to ensure appropriate investigation of the allegation of cuts, bruises and welts to the baby and properly assess her safety. The contextual circumstances of the office should be considered in imposing discipline.

The supervisor received an oral reprimand.

3. This case should be shared with the area's Regional Administrator and Child Protection Managers as a teaching tool.

The case was shared with the Regional Administrator and Child Protection Managers.

DEATH AND SERIOUS INJURY INVESTIGATION 2

ALLEGATION

A 13 year-old boy, who lived with his cousin in a relative foster placement, was fatally stabbed by the cousin's 14 year-old son in the family's home.

INVESTIGATION

The boy had initially become involved with the Department eight years earlier as a result of his mother's substance abuse issues. When he was 10, a child protection investigation was opened after the boy stabbed his then 12 year-old brother with a kitchen knife during an altercation in the family's home. Both brothers had previously reported having visual and auditory hallucinations and, following the stabbing, the boy had a major mental health disorder. An assessment of the brothers found they both exhibited overly aggressive and destructive tendencies. It was also learned that their maternal great-grandmother was largely responsible for their care because of their mother's ongoing struggles with drug dependence. While the brothers were prescribed psychotropic medications that were diligently administered by the great-grandmother, they often did not receive their dosages when in their mother's care.

Following the stabbing incident the boys were removed from their mother and placed in separate homes. Assessments determined that the combative behavior exhibited by the brothers prohibited them from living together and it was recommended they not be placed in homes with younger children. The private agency providing services to the family placed the boy in a non-relative foster home where he remained for three years. During that time the boy made great progress both academically and in gaining control of his temper. It was noted the boy was very attached to his foster mother and she demonstrated an aptitude for managing his behavior. Eventually, the boy's maternal aunt, who was caring for his brother, asked that he be placed in her home. The request was refused because of the brothers' history but the aunt's 26 year-old daughter was identified as a potential placement option. The private agency pursued and ultimately achieved having the boy moved to the home of his cousin based on a preference for having him in a relative placement. Although the cousin had a 14 year-old son and a 3 year-old daughter and private agency staff was aware the two teens would have to share a bedroom and the boy's psychiatrist had previously cautioned against placing the boy with other children, private agency staff determined the placement could proceed. Staff identified the boy's previous violent behavior as being a product of his volatile relationship with his brother who did not live in the home. The boy's case was transferred to a second private agency which was responsible for handling his brother's foster care case. Although the move required the boy to transfer schools, the second private agency had not ensured his Individual Education Plan (IEP) was forwarded to the new school. As a result the boy was placed in general classes rather than the special education program as he had been in at his old school. Private agency staff was also under the impression that Department approval was needed to forward the records though no such authorization is required.

Seven months after the boy was placed in his cousin's home police were called to the residence where they found the boy lying dead in a hallway. The cousin's 14 year-old son reported that a minor argument over use of the telephone had escalated after the boy retrieved a knife from the kitchen. The 14 year-old stated that after the boy threw a clothes iron and a trophy at him he picked up the knife and during the course of their struggle the boy was stabbed in the chest. The two teens and the three year-old girl had been left home alone briefly after the cousin left for work before the aunt arrived to watch the children. The cousin was indicated for inadequate supervision and death by neglect and surrendered her foster care license. Her 14 year-old son was indicated for risk of physical injury to his three year-old sister based on the rationale that the girl was present when the fight occurred and had been traumatized by the incident. The Abused and Neglected Child Reporting Act (ANCRA) states that in order for an individual to be an eligible perpetrator of abuse or neglect they must serve in a caretaker role. As the cousin had made arrangements for the aunt to watch the children and was herself indicated for inadequate supervision, the OIG determined it was inappropriate for the 14 year-old to have been indicated. It was further discovered during the course of this investigation that the deceased

boy's brother had been using the 14 year-old's name as an alias during multiple arrests. These actions served to give the incorrect appearance that the 14 year-old had a criminal record.

Shortly after the 13 year-old's death, the cousin and her children moved in with her mother, the foster home of the deceased's 15 year-old sibling. As a result, the 15 year-old sibling was living with the 14 year-old who stabbed his brother. The cousin reported concern about the 15 year-old's irrational behaviors including spending the night away from the home and not meeting with his mentor, individual therapist or psychiatrist.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should immediately convene a Child and Investment Team (CAYIT) with the Agency to assess the safety of the current living arrangement for the sibling of the deceased in the home of his maternal aunt, given the level of violence and mental health concerns involving both him and his cousin. The Department's Clinical Services staff should help determine how best to stabilize and engage the cousin in the most appropriate services.

A CAYIT was convened and residential placement was recommended for the sibling. He has been placed in a residential facility.

2. The Department should assist the cousin in securing appropriate housing as well as childcare and after-school resources for her children.

The family was referred for housing assistance and is now in their own apartment. The family is also attending family therapy.

3. Upon receiving a new child case, case management staff from the second private agency should verify that proper school and medical documents have been transferred to the child's new school to ensure the child's enrollment in the appropriate grade level and education programs. The agency should also educate staff that they do not need consent from the Department to transfer a child's school records.

The Department's Division of Service Intervention provided training to the agency addressing this issue.

4. As the 14 year-old boy was not an eligible perpetrator of neglect, the indicated finding of Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect (Allegation #60) should be reversed and the State Central Register should expunge the indicated allegation.

The Department agrees. The database has been updated to show allegation unfounded.

5. To alert future caseworkers, the OIG prepared a notation to be filed in the case record of the deceased boy's brother stating that he frequently employs the name of the 14 year-old boy when in contact with law enforcement.

The notation has been inserted in the boy's case file and the alias has been entered into SACWIS.

6. The Department should notify the cousin and her son, the 14 year-old boy, of the possible identity theft and direct them to appropriate resources in order to dispute any inaccurate information pertaining to the 14 year-old boy's record.

The letter was sent to the cousin.

7. The Department should request that the Guardian *ad Litem* (GAL) for the deceased boy's brother advise him to cease using the 14 year-old boy's name.

The Guardian *ad Litem* was notified.

8. A redacted version of this report should be shared with the first private agency to be used as a teaching tool for their licensing and case management staff.

A redacted report was shared with the private agency.

DEATH AND SERIOUS INJURY INVESTIGATION 3

ALLEGATION

A twenty-three month-old girl died as a result of abuse inflicted by her mother's babysitter. Four months prior to her death, the babysitter was the subject of an unfounded report of physical abuse of the girl.

INVESTIGATION

The prior abuse investigation was initiated after the girl, then 18 months-old, was brought to a hospital by her father with bruises on her face following a two-week stay in her mother's home. The day the mother took the girl into her care, she dropped the child off at the home of the babysitter and went to the home of the girl's maternal grandmother. The mother stayed with the grandmother for two weeks, helping with funeral arrangements and personal matters following the death of the grandmother's husband, while the child remained in the care of the babysitter. The babysitter told both parents the bruises were caused when the girl fell asleep on her pacifier, however physicians found the explanation to be inconsistent with the girl's injuries and identified significant bruising and swelling to the girl's mouth, cheek and jaw.

The assigned child protection investigator went to the hospital and spoke with the father, who stated he cared for the girl "95 percent of the time" and denied any knowledge the mother had ever abused the girl or that there was a history of domestic violence between them. The investigator observed the girl and took measurements of her pacifier, noting in the case record that the size of the pacifier did not match the bruise pattern on the girls' face. After speaking with the mother by phone and obtaining the consent of both parents, the investigator developed a safety plan placing the girl in her father's custody. The investigator then went to the mother's home and interviewed both the mother and the babysitter. The babysitter described the girl's injuries as being "two little scratches" and stated that in addition to sleeping on her pacifier the girl had fallen twice in the days before the injury was discovered, hitting herself against furniture. The investigator could not identify any furniture in the home that could have caused the injuries as the babysitter described. The babysitter said her 10 year-old twin daughters had witnessed the falls, as had four other children who lived in the building and were in the home at the time. One of the daughters stated she had also seen the girl fall while playing. Although Department Rule requires all witnesses to an incident to be interviewed, the investigator did not learn the identities of the other children or attempt to speak with them. In the case record the investigator recorded the building's landlord as a witness she had interviewed, however the landlord had not been in the home when the babysitter said the girl had fallen.

One week later the investigator informed the father that the safety plan was due to expire and the girl would have to be returned to the mother. The father objected and stated the girl's paternal grandmother had taken the girl to another location to ensure she would be transported for a follow-up medical appointment. The investigator told the father that only the mother could consent to the girl's medical treatment and that if the girl was not returned the mother could charge the father and grandmother with kidnapping. In an interview with the OIG, the investigator stated she assumed the mother was the custodial parent based on statements obtained from the mother and other relatives. A review of the case file showed the investigator had recorded statements from the mother that the parents shared custody and care responsibilities. The grandmother returned the girl to the mother in accordance with the investigator's instructions. Ultimately the investigator decided to unfound the report based on the rationale that she could not determine where or how the girl had sustained the injuries.

One month after the report was unfounded, the hotline received a second report against the babysitter involving a one year-old girl. The babysitter was also caring for the 18 month-old from the first investigation at the time of the incident. However, the child was not listed as a victim in the second investigation. According to the reporter, a one year-old girl was brought to a hospital with facial bruises, a skull fracture and subdural hematoma after being in the care of the babysitter, a friend of the child's family. The one year-old's

mother stated the babysitter told her the child had fallen but did not accept the explanation, as the infant had not yet begun to walk. Hospital staff reported the injuries were "extremely inconsistent with [the babysitter's] explanation" and a second child protection investigation was opened. The second investigator interviewed the one year-old's mother who said she was aware of the babysitter's prior child protection investigation and had explained it as a bogus report made by an angry former boyfriend. A physician, asked to provide an expert analysis of the child's injury, concluded that the severity and complexity of the injuries combined with the previous abuse investigation of the babysitter were cause for serious concern. In separate interviews with the OIG, the second investigator and her supervisor both stated they were familiar with the prior report. The supervisor said that while they both found injuries to a second child in the babysitter's care during a short period of time suspicious, they believed that since the report had been unfounded they could not use evidence gathered during the previous investigation. After completing her work on the case the second investigator indicated the report against the babysitter for neglect, as she was the sole adult present when the child's injuries occurred, but unfounded the report for allegations of abuse. In an interview with the OIG, the expert physician stated that she would have appealed the decision to unfound the report but said she had not been notified when the case was closed. While the Department requires that mandated reporters be informed of case closures, the OIG found that notifications originating from the State Central Register (SCR) contain only the case number and name of the alleged perpetrator. The absence of the victim's name from these notifications makes it difficult for mandated reporters, who are often involved in numerous reports, to readily identify the case.

Three months after the second case was closed, the babysitter called 911 at 11 p.m. and said the twenty three month-old girl was not breathing and had blood coming from her mouth. The babysitter claimed that earlier in the day another very young child had pushed the girl to the floor, however medical examination determined the girl was a victim of shaken baby syndrome. Several hours after being placed on life support the girl's brain function ceased and life sustaining measures were halted. The cause of death was ruled to be blunt head trauma due to assault. It was also determined that a delay of several hours had occurred before treatment was sought which was a primary contributing factor in the girl's death. The babysitter's twin girls, who were present when the girl sustained her injuries, later told authorities their mother had shaken the girl after becoming angry with her crying and had grabbed her twice by the foot and thrown her to the floor. The babysitter was charged with first-degree murder and is currently awaiting trial. During the investigation into the girl's death, her father stated he had not been notified of the second child protection investigation related to the injury to the one year-old girl and only learned of it during an encounter with the mother's landlord.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should discipline the first child protection investigator for conducting an inadequate investigation, for failing to determine when and where the alleged accident occurred, for demonstrating bias in favor of the mother against safety of the child, and for failing to indicate the investigation. The OIG would have recommended discipline for the investigator's former supervisor for failing to provide adequate supervision of the investigation and for inappropriately approving the investigation findings; however the supervisor no longer works in child welfare.

The investigator received a five-day suspension.

2. The Department should notify all parents of children cared for by a caretaker who is under investigation for abuse and/or neglect.

The OIG recently agreed to modify this recommendation and will submit the amended recommendation to the Department.

3. This report should be redacted as a training tool to dispel myths and biases concerning services to involved fathers.

The Department agrees. This case has been incorporated into the Child Protection Investigation Staff training.

4. The second child protection investigator's supervisor should receive non-disciplinary counseling to ensure that she understands that uncontested facts disclosed in a prior unfounded investigation can be considered in a subsequent investigation.

The supervisor received non-disciplinary counseling.

5. The second child protection investigator should receive non-disciplinary counseling to ensure that she understands that uncontested facts disclosed in a prior unfounded investigation can be considered in a subsequent investigation.

The investigator received non-disciplinary counseling.

6. The Department must ensure that notifications of investigation findings to mandated reporters from the State Central Register conform to Rule 300.130, and include the name of the child victim.

The Department agrees. Implementation of this recommendation is in progress.

DEATH AND SERIOUS INJURY INVESTIGATION 4

ALLEGATION

A 13 year-old girl died as a result of severe physical abuse by her mother and stepfather. A case to provide intact services to the family was closed five months prior to the child's death.

INVESTIGATION

The family had an extensive history of involvement with the Department dating back to when the girl and her twin brother were three months-old. At that time, the girl was brought to a hospital with a fractured rib and subdural hematoma attributed to shaken baby syndrome. A subsequent examination of her twin brother found he had retinal hemorrhaging and a broken rib. The mother and the children's biological father denied culpability in causing the injuries and were unable to provide any explanation for how they might have occurred. Both parents were indicated for the children's injuries as well as risk of harm and the twins, along with their six year-old brother, were placed in a relative foster home. By the time the children were returned to their mother's custody four years later, her relationship with the biological father had dissolved. A medical examination of the twins conducted while they were out of the home found that the extent and severity of their ocular injuries suggested their eyes had been intentionally gouged or poked with great force by a perpetrator with "sadistic tendencies." Although the private agency responsible for the children's placement objected to their return to the mother because the perpetrator of the abuse against them had never been conclusively identified, the court sided with the mother.

The mother's behavior throughout her 13 years of involvement with the Department demonstrated a consistent pattern of combative behavior towards child welfare and education professionals, the minimization and rationalization of injuries suffered by her children, and a failure to accept a modicum of culpability for her own actions. The mother was the subject of nine abuse and neglect reports, three of which were indicated, as a result of a vast number of injuries suffered by the children over time. The mother frequently attributed her children's health problems to birth defects and complications related to their delivery although these assertions were patently untrue. The mother utilized threats, accusations and intimidation to stymie investigations and relied on a lack of communication between involved professionals and their frequent failure to verify her statements. Soon after the children were returned to her care, the mother's boyfriend moved into the family home and the two were subsequently married. The stepfather reported he had been physically abused as a child and had a history of domestic violence. Both the mother and stepfather demonstrated a poor grasp of the children's physical ailments and accompanying limitations which contributed to the volatile nature of their household.

One child protection investigation was opened after the girl arrived at school unable to use her arm. The girl stated she hurt her arm carrying a heavy shopping bag. When the stepfather arrived at the school he reiterated the story about the girl carrying a bag and stated she was "faking for attention." The parents did not seek medical treatment for the girl for six days before taking her to their family physician after the school refused to allow her to return until she had been seen by a doctor. A medical examination of the girl revealed she had a fractured shoulder blade. During the investigation the parents and the girl cited the bag-carrying episode as well as the girl being pushed by a school bully, bumping into furniture and her inherent clumsiness as explanations for how the injury occurred. When a body scan of the girl found numerous old scars on her face, knees and back, the girl said she could not remember how they had been caused. Multiple circular scars found on the boy's front and back torso and linear marks to his face and neck were unexplained. Although the girl was seen by her family's physician, the doctor focused solely on the shoulder injury and did not conduct a full examination. The physician had treated both children since their birth and was aware of the family's history with the Department. An OIG review of the physician's case file for the family found that while she was aware of the history of abuse in the home she recorded no concerns about the girl's overall health or welfare. The child protection investigation was ultimately indicated for bone fractures by an unknown perpetrator and indicated against the mother and stepfather for risk of injury by neglect. The parents

appealed the decision and the Department voluntarily withdrew the findings.

Ten months after the indicated finding was withdrawn and following another indicated report, the girl was taken for medical treatment after arriving at school with swelling to both sides of her face and two black eyes. The police reported the child had visible injuries. The attending doctor identified possible child abuse and took the girl into protective custody before having her transferred to a hospital that employed a child protective services team for evaluation. However, upon her arrival the girl was seen and no sign of abuse was noted. The black eyes were attributed to prior ophthalmologic treatments and she was released to her parents' custody. The hospital's child protective services team was never notified of the girl's presence in the emergency room as there was no internal mechanism allowing for automatic notification when a child is admitted under protective custody.

Four months later the girl was brought to another hospital's emergency room and pronounced dead on arrival. The medical examiner identified extensive scarring, bruising and abrasions across her entire body. An internal exam found hemorrhaging in her brain, lungs and liver and physical wasting of her muscle mass. The medical examiner determined the girl's death was a homicide as a result of child abuse. The mother and stepfather were charged with first degree murder and are currently awaiting trial. The boy was placed in a relative foster home through a private agency that provides services to children with special needs.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. In cases involving severe, multiple injuries to children, when it is left unclear at the close of the child protection investigation which of the parents inflicted the injury, the investigation should be reviewed jointly by the DCP Manager and the DCFS Office of Legal Services to ascertain whether any additional investigation may assist the Department in determining which perpetrator was responsible and whether to pursue immediate termination of parental rights.

The Department wishes to clarify that per DCFS Rule 300.20 Definitions, a "Formal Investigation: means those activities conducted by the Department investigative staff necessary to make a determination as to whether a report of suspected child abuse or neglect is indicated or unfounded. Such activities shall include:…a determination of the nature, extent and cause of any condition enumerated in such report…and an evaluation as to whether there would be an immediate and urgent necessity to remove the child from the environment…"[325 ILCS 5/3]. In other words, the burden of determination, according to DCFS Rule and Procedure and the existing laws, lays with the investigative staff. However, the Department investigative staff consults routinely with DCFS Legal Services on cases where there is a question of legal sufficiency to pass screening. Moreover, it is DCFS Legal Services' responsibility to review every new Temporary Custody Case for Early Termination of Parental Rights (ETPR). When DCFS Legal Services' staff establishes that Expedited Termination of Parental Rights is appropriate, they send a form memo to the Assistant State's Attorney's Office for ETPR consideration.

2. The Department should apply for a Supplemental Security Income (SSI) grant for the boy.

The boy was approved for SSI.

3. This report should be shared with the child protective services team from the hospital where the girl was taken under protective custody for consideration of changes to their internal procedures that would have ensured that a child taken into protective custody is referred to the Child Protection Services Team.

The Office of the Inspector General shared a redacted copy of the report with the child protective services team.

4. This report should be shared with the Office of the Public Guardian.

The Office of the Inspector General shared a redacted report with the Public Guardian.

5. The DCFS Medical Director should review the quality of patient care provided to the girl by the family's physician.

The Department agrees. The Healthworks Provider Credentials Committee is currently reviewing the physician's credentials; contacting the caregivers of children/youth that are linked with this physician; and reviewing the central file records for the children/youth who are confirmed as still seeing the physician for primary care.

DEATH AND SERIOUS INJURY INVESTIGATION 5

ALLEGATION

A baby delivered by a 17 year-old girl at 20 weeks gestation died shortly after birth. One week prior to the delivery, the girl had been the victim of domestic violence by her father. Two abuse reports against the father, including one related to the altercation with the girl, were unfounded by the Department.

INVESTIGATION

The first abuse report involving the family followed an incident in which the father located the mother at the home of a friend, broke down the door and physically assaulted her. The father was arrested and charged with forced home invasion and aggravated battery. The child protection investigator assigned to the case first interviewed the mother in the family home. The mother stated the father had a history of domestic violence that had previously gone unreported but said she expected the father to be incarcerated for some time and that she had registered with a national organization that would alert her if his release was imminent. The following day the investigator again met with the mother along with the couple's three daughters, the 17 year-old and her two younger sisters, ages 15 and 14. The girls denied any knowledge of violence between their parents and stated they were not afraid of their father.

The investigator conferred with her supervisor and a decision was reached to unfound the report, based on the expectation the father would remain in jail and the contingency plan the mother had developed with the girls' school to shield them from their father if he was released. The investigator completed her work on the case without performing required duties, such as interviewing the alleged perpetrator, the father, or obtaining the official report of the incident from law enforcement. The investigator also neglected to speak with staff from the school. In an interview with the OIG, the school social worker stated she was never contacted by the investigator. The social worker stated that following the incident, the girls were in constant fear and the 15 year-old, who had just been hospitalized for suicidal ideation, was particularly afraid that her father would kill her mother or arrive at the school to hurt them. The investigator never confirmed the mother's registration with the national notification organization. An OIG review found no record the mother registered with such an entity. The investigator's supervisor did not secure waivers permitting the investigator to close the case without required interviews being performed, and signed off on the investigation without ensuring all tasks had been completed.

Six weeks after the first investigation was unfounded, a second investigation was initiated after the father was involved in a physical confrontation with the 17 and 15 year-olds in a dispute over the use of a car. The father slapped, scratched and wrestled with the 17 year-old, who was 19 weeks pregnant, eventually throwing her to the ground. He then choked the 15 year-old who tried to intervene before entering the home and tearing a phone out of the wall that the 14 year-old was using to call police. The father then fled the home before officers arrived. The report related to this incident was assigned to a second child protection investigator who went to the family home and spoke to the mother. The mother minimized the incident, saying the girls all had behavioral problems, and refused to allow the children to be interviewed. The second investigator later spoke to two of the girls who dismissed the episode as a family argument. Although the father was charged with domestic violence, the girls refused to testify in court and the charges were dropped. Following dismissal of the charges, the second investigator met with her supervisor and a decision was reached to unfound the report. The judgment was based on the resolution of legal proceedings, the 17 year-old's statement she was not afraid of her father, the fact the three girls were teenagers and the family's general refusal to cooperate with the investigation. The second investigator and her supervisor did not consider the content of the extensive, detailed statements all three girls provided to police in the direct aftermath of the incident. The investigator and her supervisor also did not review police records showing two prior incidents of domestic violence at the home, including one in which the 14 year-old brandished a kitchen knife in an effort to protect the 15 year-old from the father. The second investigator did not learn of the premature end of the 17 year-old's pregnancy until after the report had been unfounded.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should pursue disciplinary action against the first child protection investigator for failing to obtain relevant

police records, interview the mandated reporter and not requesting waivers for the required contacts.

The investigator received an oral reprimand.

2. The Department should pursue disciplinary action against the first child protection investigator's supervisor for her failure to ensure that the required investigative activities were completed.

The supervisor was counseled.

3. The Department should pursue disciplinary action against the second child protection investigator for unfounding an investigation in which there was adequate information to indicate.

The investigator resigned from the Department prior to discipline being imposed.

4. The Department should pursue disciplinary action against the second child protection investigator's supervisor for unfounding an investigation in which there was adequate information to indicate.

The supervisor received a 5-day suspension.

5. The first and second child protection investigators as well as both of their supervisors should participate in the web based domestic violence training offered by the Office of Training and Developmental Services.

The Regional Domestic Violence Specialist provided domestic violence training to the child protection staff.

6. A domestic violence specialist from the Division of Clinical Practices and Professional Development should convene a case discussion session with the involved child protection staff to review the failures in this case.

The Regional Domestic Violence Specialist facilitated a clinical case review with the four CPS staff involved with this case. The session lasted 2.5 hours and included a thorough review of the case and an overview of relevant domestic violence practice principles.

7. A domestic violence specialist from the Division of Clinical Practices and Professional Development should oversee all child protection cases involving domestic violence in the local area field office for the next six months to ensure that these investigations are given the attention and expertise critical for the protection of children and families involved in domestic violence situations.

The Regional Domestic Violence Specialist facilitated an in-service training about domestic violence policy and practice principles at that DCFS Office. Thirty-six DCP investigators and supervisors participated in this half-day training. Staff were advised to consult with the Regional Domestic Violence Specialist on cases involving domestic violence, especially over the next 6 months to enhance their practice. Following this training, the Regional Domestic Violence Specialist met with the nine supervisors who participated in the training about a plan for on-going consultation. The Regional Domestic Violence Specialist will send out a monthly email to these supervisors as a reminder and to inquire about any cases involving domestic violence.

DEATH AND SERIOUS INJURY INVESTIGATION 6

ALLEGATION

A three month-old girl died of undetermined causes. A child protection investigation of the girl's mother was pending at the time of the baby's death.

INVESTIGATION

The mother had an extensive history of involvement with the Department, child welfare agencies, and medical and mental health care stemming from her significant physical and emotional issues and unstable lifestyle. She reported having been abandoned by her mother as a child and being left with relatives who physically and sexually abused her. The mother's oldest child had tested positive for cocaine at birth and was surrendered for adoption. The mother was unable to maintain a consistent residence and had no support system to assist her in meeting her needs or the needs of her second child, a three year-old boy, who remained in her care.

One month before the mother gave birth to the girl she contacted the agency that had handled her previous adoption and stated she was in "dire" need of help as she would be overwhelmed by the responsibility of caring for a second child. The mother stated her desire to surrender the baby for adoption and agreed to have the adoptive parents of her first child take custody of the baby. At the time the baby was born, the mother became aggressive towards hospital staff, accusing them of forcing her to give her baby up for adoption, and was admitted to the hospital's psychiatric ward. The baby was born with a heart defect. The mother informed the adoption agency she did not wish to proceed with the adoption but could not care for the baby herself. The mother then contacted a private agency that administered a program in which children are placed in the unlicensed respite homes of volunteer families to provide assistance to families in crisis. The mother was accepted into the program and the baby was placed with a volunteer couple. The OIG reviewed the program's intake questionnaire and found that the document did not record the issues that brought the family into crisis, a plan to provide stability or the overall goal the family was seeking to achieve. In an interview with the OIG, the case manager stated that while host families in the program are monitored the biological families are not. The case manager said the program does not wish to "intrude" on families in crisis and that children are returned to parents at their request. The case manger stated she relied upon referring agencies to provide case management and share background information, however the mother had contacted the program herself as the adoption agency withdrew its services after she decided not to proceed with the adoption. Three weeks after the family entered the program the mother informed the case manager she wanted to raise the baby herself and the girl was returned to her custody.

One month later the mother contacted a worker at the adoption agency and engaged in a bizarre, rambling diatribe. The worker described the mother as being "intensely enraged," saying she made statements related to killing herself and her children and claimed to have put a fatal curse on a housing worker who failed to adequately assist her. Although the mother had been hospitalized four times in the past following suicide attempts, law enforcement determined she had not made any clear or specific threats. A child protection investigation initiated to address the mother's behavior was still pending one month later when the mother arrived at a hospital with the baby in her arms saying the infant had succumbed to a fever. The baby was pronounced dead on arrival and a medical examination found she had been deceased for a longer time than had been stated in the mother's account. Doctors were unable to identify a specific cause of death and returned a finding of undetermined. The baby had been born with a heart defect and, in response to the medical examiner's conclusion that the mother's actions or inactions had led to the baby's death by neglect, the child protection investigation of the death returned an indicated finding against the mother. During the investigative interview, the mother stated the baby had passed away because, "it was her time to die and she did and that was that."

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should implement the revised Adult Substance Abuse Screen.

The revised Adult Substance Abuse Screen has been posted on the Department's D-Net and included in the SACWIS templates.

2. The Department should convene a meeting with the staff of the adoption agency, the private agency and the physician in response to the adoption agency's letter regarding the baby's death.

Department staff from the Division of Clinical Services met with staff from the adoption agency and the private agency to review the case.

3. The private agency program's staff should meet with their board and discuss an intake process that screens clients for severe mental illness and substance abuse. Program staff could benefit from training that teaches them how to refer clients identified with severe mental illness and dual diagnoses to appropriate programs for services.

The Office of the Inspector General shared a redacted copy of the report with the private agency. The Inspector General met with agency Administrators and a member of the agency's Board of Directors to discuss the agency's intake process.

4. This report should be shared with Department staff working with the family to provide an historical perspective of the case.

The Regional Administrator shared the report with staff working with the family.

DEATH AND SERIOUS INJURY INVESTIGATION 7

ALLEGATION

A three month-old girl died of natural causes. A child neglect investigation of the baby's mother was unfounded two months prior to the infant's death.

INVESTIGATION

The mother had an extensive history of involvement with the Department, dating back to when she became a ward at age 11 as a result of abuse and neglect inflicted by her mother and other caretakers. The mother reported she had been sexually abused by her father, forced into prostitution by her mother and sold drugs as a child on behalf of her parents, who were both heavy users. In the seven years she remained in the care of the state, the mother resided in 21 different placements. During the seven years following her emancipation, the mother gave birth to four children. Her first involvement with the Department as a parent came prior to the birth of her fourth child when she left her three oldest children in the home of their maternal grandmother without permission or a care plan. As an adult, the mother struggled with ongoing issues of substance abuse, domestic violence, behavioral problems, poverty and homelessness as well as her children's special needs. The mother was the subject of 10 abuse and neglect reports including the one just prior to the death of her fifth child.

The most recent hotline report was made after the mother's two oldest children, ages 9 and 7, were observed unattended at the hospital after she was admitted in anticipation of her delivery. Hospital staff observed the children both before and after the birth moving unsupervised throughout the room and surrounding area and caring for the newborn. A child protection investigator was assigned to the case and visited the mother at the hospital. The mother told the investigator the family had been residing at a local homeless shelter; however, shelter policy maintains that children were not allowed to remain without their parents so the oldest two stayed with her at the hospital while the younger two stayed with relatives. The mother stated she had recently regained custody of her children and had made an effort to remain clean prior to the baby's birth to ensure they all remained with her.

The investigator relied heavily upon the mother's self-report and did not verify much of the information provided to her. There was no evidence in the case file of contacts with the homeless shelter, the substance abuse treatment facility or the relatives caring for the two younger children. In an interview with the OIG, the investigator stated she did not conduct a visit to the homeless shelter because she was familiar with the institution and knew it to be a safe environment. The investigator said the mother provided her with a certificate of completion from the substance abuse treatment program, however no such documentation was found in the case file. A review of police records found that in the 10 days prior to the baby's birth, the mother had been cited in three police reports related to theft of a motor vehicle, criminal trespass and possession of a controlled substance.

Although the investigator made her decision to unfound the report based on the mother's efforts to ensure "safe" environments for her children while she was hospitalized and because of the mother acknowledgement that her 9 year-old should not have cared for the newborn, the investigator did not consider the totality of the issue confronting the family. A more comprehensive evaluation of the family's history, particularly the mother's multitude of ongoing issues, could have resulted in the family being offered services through the Department. Although the mother would have been under no obligation to avail herself of services, it is the responsibility of the Department to ensure clients are made aware that those services exist.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator and her supervisor should receive non-disciplinary counseling for failing to offer services to the family after unfounding the investigation. The investigator should be instructed to enter all contacts made in her contact notes or in the State Automated Child

Welfare Information System (SACWIS).

The Department agrees. The counseling will be conducted.

2. The Department should attempt to locate the family and offer services. This report should be shared with the assigned caseworker and supervisor. The family should be monitored closely to determine whether an order of protection should be sought, given the children's repeated exposure to domestic violence and need for services.

Although the family was located, the family cases were closed since 1996. The Intact Case was Court Released in 2006 and a relative was granted custody and guardianship. The following services have been provided to the surviving siblings: Comprehensive health exam; Developmental screens; Head Start; Counseling links in school; SSI benefits.

DEATH AND SERIOUS INJURY INVESTIGATION 8

ALLEGATION A nine year-old boy died of asphyxiation after swallowing a plastic toy. The boy and two siblings were adopted one year earlier by their licensed foster parents. Two child protection investigations of the family were conducted during the three months prior to the boy's death.

INVESTIGATION The adoptive parents were licensed four years earlier through a private agency to have four children placed in their home. Three months later the private agency placed four siblings, ages 5 to 12, in the home. All four of the foster children had diagnoses that required psychotropic medications. Two years later, the oldest sibling was removed from the home and one year later the foster parents adopted the three younger siblings, however, the adoption subsidies did not reflect their diagnoses or the need for medications. Several months after the adoptions, the private agency placed a 10 year-old child in the home for 3 months.

Shortly after the 10 year-old was placed, a hotline report of substantial risk of physical injury was investigated against the adoptive mother involving her 16 year-old adoptive daughter. The investigator made several unsuccessful attempts to see the daughter before she was interviewed at school. The investigator completed a safe CERAP without ever seeing the girl in her home. The mother was interviewed over the phone. The investigator did not identify other members of the household or the situations in the home before determining there was no need for further investigation. The substance abuse and domestic violence screens were completed by phone. The supervisor signed off on the documents without noticing that the interview was by phone. The investigator never determined whether there were other household members that should have been interviewed or that the parents were licensed foster parents and the agency should have been notified. The investigation was unfounded based on insufficient evidence to support the allegation. Shortly after the closed investigation, the private agency placed a foster child back in the home.

Eight weeks later there was a second call to the hotline reporting substantial risk of physical harm with the 16 year-old as a victim along with her eight and nine year-old siblings. The allegation was that the adoptive mother hit the children with objects including a broom, shoes, switches and a belt. The investigator went to the home and was given the contact information for the mother's private agency licensing representative. The investigator made one attempt to contact the licensing representative and when told there was no one by that name, made no further inquiries of the agency. The eight and nine year-old children denied any corporal punishment as did the parents. The 16 year-old was on run and was not interviewed. The investigator also learned that the 16 year-old was now pregnant. The DCP investigator recommended the report unfounded based on insufficient evidence.

Although the home was licensed at the time of the child abuse and neglect investigations, the case was not flagged as a foster home facility. Even though a ward lived in the home at the time of the second investigation, the ward was not identified as a member of the household or as a ward living in the home. Neither DCP investigation followed up with information that would have revealed the home as a licensed foster home with an active license. There was no information in the private agency's records to support that the Department notified the private agency of either DCP investigation. Further, the Department's Agency & Institution Licensing unit confirmed to the OIG investigator that the unit did not receive notice from the SCR or DCP of any child protection investigations involving the family. The second investigator reported to OIG staff that had he known that this was a licensed foster home, he would have notified the private agency of the pending DCP investigation.

During the OIG investigation, it was learned that the foster child in the home was a special needs child and the case record lacked critical documentation and information pertinent for effective case management.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The SCR Administrator should issue an instructional memo to all SCR operators that when an incoming Hotline call identifies that the allegation involves, "foster parent, foster home, foster child, adoptive parent, adoptive home, or DCFS ward," the SCR operators' data checks must include a Provider Name Search and a check for placements. When the subject and/or home are found to a provider/facility *Facility* box and *Facility Type* drop list must be checked when completing the Intake Summary screen in SACWIS.

The SCR Administrator issued the instructional memo to staff.

2. The DCP investigators from both investigations should be counseled on referring adoptive families, who have children in crises, for adoption preservation services.

The investigator from the first investigation was counseled. The investigator from the second investigation received a two-day suspension.

3. The DCP investigators from both child protection investigations should be counseled on the importance of completing detailed data checks on subjects of investigations.

The investigator from the first investigation was counseled. The investigator from the second investigation received a two-day suspension.

4. The Department should consider discipline for the child protection investigator from the second investigation for failing to contact the family's licensing worker.

The investigator received a two-day suspension.

5. The adoptive family should be offered adoption preservation services focusing on the 16 year-old's teen pregnancy and supportive mental health services.

The case was referred to the Department's Post-Adoption Unit. A referral was made to an adoption preservation agency for assessment and the provision of on-going services.

6. The Department's Clinical Services should review the adequacy of the adoptive family's adoption subsidies.

A Clinical Consultant was assigned to this case and the case has been staffed on three occasions. Adoption preservation services and other supportive services have been provided to the family. During her pregnancy, the 16 year-old was referred to a program specializing in psychiatric and supportive services to pregnant women and teens diagnosed with mental illness. Since the birth of the baby, the 16 year-old has been receiving services from a program for high risk teen moms that provides individualized case management services including a weekly parent support group.

7. The private agency with assistance from the Department must expedite the specialized foster care services that the 10 year-old foster child is entitled to receive.

The child's case was transferred to an agency with specialized foster care services.

8. The private agency administrators should address the absence of relevant documentation in the child's case record.

The Office of the Inspector General shared a redacted copy of the report with the private agency. The Inspector General met with agency administrators and a member of the agency's Board of Directors to discuss the findings and recommendations made in the report. The agency reviewed the case file and addressed the absence of relevant documentation.

DEATH AND SERIOUS INJURY INVESTIGATION 9

ALLEGATION A three month-old girl died of rollover asphyxiation in the home of her paternal grandmother, a licensed foster parent. A child protection investigation of the girl's parents, who lived in the grandmother's home, was unfounded seven weeks before the baby's death.

INVESTIGATION The infant's mother and her seven children, the oldest of whom were eight year-old twins, had moved into the paternal grandmother's home after being kicked out of the children's maternal grandparents' home seven months earlier. The infant's father already resided in the paternal grandmother's home, as did a nine year-old boy residing in a non-relative foster placement. The living space provided for the mother, father and the children was a room in the unfinished basement of the home. The family became involved with the Department after an allegation of inadequate shelter was made, charging that living conditions in the basement were unsuitable for children. The child protection investigator assigned to the case unfounded the report. The OIG was unable to review the case record as it was expunged 30 days after a final determination of the case, in accordance with Department rule. The child protection investigator did not notify the private agency that held the grandmother's foster home license about the existence of a child protection investigation involving the home. The investigator was not aware the residence was a licensed foster home because the report had been accepted at intake by the State Central Register (SCR) without designating the home as a "facility" or noting that a Department ward lived at the location. The investigator did not conduct required checks of Department databases to obtain historical information on the family which would have alerted her to the presence of a foster child in the home.

Simultaneous to the child protection investigation, a licensing worker from the private agency was processing a renewal of the grandmother's foster home license. Unaware of the pending investigation of inadequate shelter, the licensing worker visited the family home and recorded only the grandmother, her foster son and the mother and father as residents. The licensing worker did not conduct a background check on the mother, which would have alerted him to the pending investigation. In an interview with the OIG, the licensing worker incorrectly asserted that the father was named on the foster care license as a backup care provider, which the worker believed precluded the necessity of running a check on the mother. An OIG review of the licensure file found the licensing worker frequently either failed to perform required tasks or submitted documentation of responsibilities that had only been partially completed. While conducting his home inspection the licensing worker observed two padlocked doors in the unfinished basement and accepted the grandmother's explanation that they led to storage rooms. An inspection by the worker after the baby's death found one of the rooms to be the space inhabited by the mother and the children which contained three beds and a crib as well as a refrigerator, sink and bathroom. Following the baby's death, all of the children were removed from the home and the licensing worker recommended that the grandmother's license be revoked for failing to notify the agency that the mother and her children had moved into the home. Currently the grandmother still holds her license as a result of the licensing worker's failure to complete necessary documents. The Placement Clearance Desk has put a "hold" on the home to ensure no other children are placed there.

The grandmother's foster son has lived in four residential placements and one group facility since being removed from the home. A review of his case file shows that while involved with the private agency he has not been timely evaluated for purposes of education, placement or services. Since coming into care, he has endured the termination of his parent's rights, the death of a foster parent, numerous placements and removal from the home he had lived in the longest. It is imperative that the private agency devote adequate attention and care to ensuring the boy's needs are met.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency should consider discipline for the licensing worker for conducting an inadequate license renewal of the

grandmother and her home, mitigated by the agency staff shortages when the licensing worker assumed responsibility for the foster care program. When conducting a license renewal of the grandmother's home, the licensing worker should have examined rooms that were secured by padlocked doors, gathered family information for assessment purposes and to update an existing home study, and obtained a background check of a child care provider named in a Supervision Plan for foster children.

The Office of the Inspector General shared a redacted copy of the report with the private agency. The Inspector General met with agency Administrators and a member of the agency's Board of Directors to discuss the findings and recommendations made in the report. The agency's vacant staff positions have been filled and foster care staff has been cross-trained in foster home licensing in the event of another staff vacancy. Agency Licensing staff coordinated with the Department's Agency Performance Team staff to arrange for training licensing staff. In addition, the Agency's Quality Improvement Office reviewed 100% of the Agency's foster home licensing files taking corrective action steps as necessary.

2. The grandmother's former foster son should *immediately* receive specialized foster care services to ensure that his long-term education and mental health needs are properly addressed, including supplementary education supports, and that medication management is properly administered and monitored. The boy's current foster home placement should be assessed to determine whether his foster parents can meet his special needs with appropriate supports.

The child's case was transferred to an agency that offers specialized foster care services. The foster home was assessed and determined to be able to provide for the boy's needs.

3. The State Central Register operators taking incoming Hotline calls should be reminded that, when completing the Intake Summary Screen in SACWIS, they should check the *Facility* box when the Report mentions "foster parent," "foster home," and/or "foster child."

A Practice and Procedural Memo addressing this recommendation was distributed to SCR staff.

4. The Inspector General previously recommended a modification of the SACWIS system so that the system has necessary data capable of (1) identifying foster parents when their names are entered into the 'Person Search' option and (2) notifying the Department's Agency and Institution Licensing Unit and foster care licensing agency when the State Central Register receives a report involving a licensed foster home. This modification is still necessary and critical as the functions would not only assist child protection workers in identifying licensed foster homes in the initial stages of investigations but would also complement the efforts Department staff who are responsible for adhering to Procedures 383: Licensing Enforcement.

The Department agrees. The modification has been implemented.

5. The child protection investigator should receive counseling on the importance of notifying appropriate entities when a licensed foster home is involved in a DCP investigation as delineated by Procedures 300 and 383. The investigator should be counseled regarding her responsibility to conduct database searches on persons or locations that are referenced as "foster parent, foster child or foster home" in the Narratives of hotline reports.

The investigator was counseled.

6. The Department should pursue an amendment to ANCRA extending the 30-day retention period to six months after a final finding is entered for unfounded reports involving licensed foster homes made by non-mandated reporters.

The DCFS Office of Legal Services has assigned an attorney to draft amendments to ANCRA which address the above issue as well as other proposed changes to ANCRA, and will submit these amendments as a single legislative package.

DEATH AND SERIOUS INJURY INVESTIGATION 10

ALLEGATION

A 15 year-old girl committed suicide in her home. A child protection investigation was opened as a result of conditions observed in her family's home at the time of her death.

INVESTIGATION

The family was comprised of the girl, her father, her stepmother and three younger siblings, a seven year-old girl and boys ages six and four. The family's first involvement with the Department occurred three years earlier after police ordered the children removed when they found illicit drugs in the family's home and observed it to be in a "deplorable" state. A second hotline report was made the following year alleging the father had physically abused his younger daughter. The couple acknowledged using corporal punishment to discipline the children but minimized the alleged abuse to the seven year-old, despite medical evidence the girl had been slapped with "significant force" across the face. A neighbor told the investigator assigned to the case that she frequently heard "smacking" sounds emanating from the family's apartment and said the father abused crack cocaine and both parents used drugs. It was also stated that the older daughter, then 13 years-old, was responsible for maintaining the household and served in a parental role for the younger children. The girl reported to the investigator that she was concerned about the presence of suspicious men in the family's home she identified as drug dealers and said she felt overwhelmed by her responsibilities as head of the household. At the conclusion of the investigation the father was indicated for abuse of the girl. However other indicated findings against both parents related to risk factors in the home and the condition of the living environment were overturned on appeal. The family was referred for intact services but was minimally compliant performed only required tasks.

During the course of the intact family services case, both the father and stepmother reported having been physically abused by their own families when they were children. The father was marginally employed and was described by his oldest daughter as a "vegetable" who spent most of his time on the couch in the home. The stepmother reported having been diagnosed with a major mental health disorder but refused to receive treatment because she did not believe in using medication to treat mental illness. The intact services worker noted concerns regarding the parents' perception of the family situation, the children's emotional development and the poor condition of the home. Throughout their involvement with intact services the parents were uncooperative and performed only the minimum of required tasks. Once they had completed the parenting classes the father had been ordered to attend by the court, the couple requested that their case be closed and refused further services. Although intact services staff had learned a great deal about the myriad issues present in the family's home, the information gathered was never shared with the court.

Four months after the case was closed, the stepmother found the 16 year-old girl hanging by her neck in her bedroom closet. When paramedics arrived they found the body of the deceased girl lying on a bed where the stepmother had placed her. The paramedics then realized the seven year-old girl was asleep under a pile of clothes on the same bed. Authorities who visited the home after the girl's death reported it to be in a severe state of disarray. During the subsequent child protection investigation, relatives, neighbors, school personnel and medical professionals all came forward with concerns about the parents' heavy substance abuse, mental health issues, inadequate supervision and care of the children, and inability to maintain a safe household. Several of these individuals stated they had made reports to the Department or law enforcement agencies but said the parents were adept at concealing the extent of problems in the home and frequently bragged of their ability to mislead police and child welfare professionals.

Six weeks after the girl's death, another hotline call was made alleging inadequate supervision after it was reported the couple's three young children were allowed to play in the street and that the family was living in squalor.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department's Office of Legal Services should review records on the family and assist the Department in screening this case into court and pursue, at a minimum, a protective order requiring the parents' cooperation with services.

The Department agrees. A protective order mandating psychological and substance abuse assessments and compliance with recommended treatment and cooperation with Department service plan tasks was obtained. The case remains open with Intact Family Services.

DEATH AND SERIOUS INJURY INVESTIGATION 11

ALLEGATION

An 18 month-old boy with multiple serious medical conditions died of natural causes. At the time of the boy's death a report of medical neglect against his mother was pending.

INVESTIGATION

The boy's mother, who was 16 years-old at the time of his birth, was induced to deliver early after doctors determined the baby's *in utero* growth was poor. At birth the boy presented significant medical complexities including diabetes, epilepsy and a rare brain disorder that required consistent monitoring and treatment with medication. Within six months of the baby's birth, three reports were opened against the mother for medical neglect of the boy. All three reports were handled by the same child protection investigator and dealt with how frequently the boy received his medicine. Handling the first two reports simultaneously, the investigator contacted the boy's physician who stated the child was receiving adequate medical care. Based on the doctor's assurance the boy's needs were being met and a review of medical records, the first two reports were unfounded.

In the course of conducting the third investigation, the investigator again consulted with physicians but did not perform another review of the boy's medical records. The investigator also did not make specific inquiries as to what medicine the boy was prescribed or the potential ramifications if dosages were missed or sporadically administered. The mother admitted to the investigator she frequently failed to give her son his medicine as scheduled and only became diligent in anticipation of appointments with his doctor. The report was ultimately indicated against the mother for medical neglect. An agreement was reached that the mother would turn custody of the boy over to his maternal grandmother and the investigator completed a safety plan signed by the mother and maternal grandmother confirming the arrangement. The family was not referred to the Extended Family Support Program to facilitate completion of a petition for private guardianship. Instead the maternal grandmother was instructed by the investigator to file a motion in probate court independently. In an interview with the OIG, the investigator stated she was informed by the maternal grandmother of the date she anticipated obtaining private guardianship but did not secure documentation from the family. In a separate interview with the OIG, the investigator's supervisor stated she did not seek for the case to be referred to the Extended Family Support Program because she was under the impression private guardianship had already been obtained.

One year after the report was indicated, a fourth report of medical neglect was made against the mother. A second child protection investigator assumed responsibility for the case and contacted another physician involved in the boy's care. The physician expressed concerns regarding the mother's compliance with the boy's medication schedule. Two weeks after the report was made the boy died after being brought to a hospital emergency room by his paternal grandmother who had observed he was having difficulty breathing. The boy's death was attributed to natural causes related to his multiple congenital anomalies.

Throughout the family's involvement with the Department, the boy's severe physical ailments and the numerous health care workers and institutions involved in his care proved an obstacle for child welfare professionals attempting to ascertain appropriate sources of information. Currently, child protection investigators are not allowed access to Medicaid information possessed by the Department of Health Care and Family Services. Making this information available to child protection investigators would allow for easier identification of involved health care providers and ongoing courses of treatment.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Child protection managers should be instructed to issue administrative subpoenas to the Acting General Counsel of the Department of Healthcare and Family Services in child

protection investigations when they are seeking information related to Medicaid benefit claims.

The Department agrees. The instruction will be sent to Child Protection Managers.

2. The Department should pursue an interagency agreement with the Department of Healthcare and Family Services allowing DCFS Division of Child Protection staff access to Medicaid Benefit Claim information.

The Department of Healthcare and Family Services notified DCFS that the 2004 interagency agreement would allow the necessary access. Representatives from DCP and the Guardianship Administrator's Office will coordinate with the Department of Healthcare and Family Services to implement this recommendation.

3. The Department should issue a memo reiterating the availability of the DCFS Medical Director to consult in cases of medical neglect.

The Department issued Policy transmittal 2008.09 - Nursing Consultation Services for Children with Special Health Care Needs to address this recommendation.

4. As previously recommended by the Office of the Inspector General in FY 2007, Department procedures should be amended to require that in child protection investigations in which the plan is for a family member to obtain private guardianship of the child/ren, the family should be referred to the Extended Family Support Program for assistance in securing private guardianship.

The Service Intervention Deputy has reviewed and approved the draft procedure. The procedure has been sent to the Office of Child and Family Policy for the revision process.

5. This report should be shared with the first child protection investigator and her supervisor as a teaching tool.

The report was shared with the investigator and supervisor.

DEATH AND SERIOUS INJURY INVESTIGATION 12

ALLEGATION

A two month-old girl died of natural causes. The infant and her two year-old brother had been removed from their mother and taken into the Department's custody two months prior to the baby's death.

INVESTIGATION

The two young children were taken into Department custody after their mother was arrested for driving under the influence at 2:00 a.m. with both children in the car, neither of whom was properly secured in a car seat. Although the children's father was incarcerated at the time and the mother refused to provide the name of a relative who could care for them, police identified the maternal grandmother who agreed to serve as a caretaker. The mother had an extensive history of involvement with the Department and had two older children already residing in the maternal grandmother's home. The child protection investigator assigned to the report did not meet with the family until one week after the incident. In an interview with the OIG, the investigator stated that in her experience safety plans are initiated before she receives a case, so she assumed one had been put in place. No safety plan had been established prior to the investigator beginning work on the case.

Upon meeting with the family, the investigator was informed the maternal grandmother had already returned the two youngest children to their mother's custody. The grandmother and her adult daughter told the investigator that their entire family was fearful of the mother because of her propensity for combative behavior. The daughter stated the mother had, "a violent streak in her and [the investigator would] probably have to call the police" to see the children. The investigator met with the mother's two older children who also related concerns about their mother's propensity for physical confrontation and reported a previous incident when she had broken the grandmother's arm. The investigator then went to the mother's home where she was initially denied entry. The mother was verbally aggressive and told the investigator to contact the police if she wanted to gain entry to the home. While awaiting the police's arrival, the investigator called her supervisor to inform her of the situation. The supervisor instructed the investigator that after the police arrived she should visit the children and advise the mother to refrain from engaging in corporal punishment. The supervisor, who was serving in a temporary capacity, told the investigator to leave the children in the home and that a decision on their placement would be made a few days later after the regular supervisor returned. After gaining entry to the home with the assistance of police, the investigator saw the children and observed a healing burn mark on the two year-old's chin which she determined was an older injury. The investigator completed a Child Endangerment Risk Assessment Protocol (CERAP), which determined the children to be safe in their mother's custody. The investigator then informed the mother she would be returning to the home soon to open a case for intact family services.

In her interview with the OIG, the investigator stated she disagreed with the supervisor's decision to leave the children in the home and that she wanted to take the children into protective custody while accompanied by police. The investigator stated she was aware she could have sought approval to do so from a child protection manager, but did not believe such action would have produced a different result. The investigator said she was familiar with the mother's previous Department involvement and was also aware of her extensive criminal history. In her interview with the OIG, the temporary supervisor stated she approved the CERAP based on the investigator's observation that the children were "healthy and showed no signs of abuse or neglect," but did not consider the other factors presented in the assessment.

After the investigator's regular supervisor returned, a decision was made to screen the case into court. Police assistance was again required to ensure the investigator was able to gain entry to the home and the children were removed and returned to the maternal grandmother's custody. Following a formal investigation of the drunk driving episode, the mother was indicated for substantial risk of physical injury by neglect and inadequate supervision. Five weeks after the report was indicated, paramedics were called to the maternal

grandmother's home after the two month-old girl was found unresponsive. Medical personnel were unable to revive the infant, whose death was ruled to have been caused by sepsis and viral pneumonia.

As the other children remained with the maternal grandmother, a recommendation was made to provide services through the Extended Family Support Program (EFSP). The plan is intended to provide assistance to relative caregivers and help stabilize children in these placements. An OIG review of the EFSP program plan identified vague language and unclear guidelines pertaining to eligibility for services, particularly in regards to children whose custody is being contested. The OIG recognized that uncertainty regarding what constitutes a "contested" matter could interfere with the timely and efficient delivery of services to children.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be counseled for her poor judgment in assessing the safety of two young children.

The investigator was counseled.

2. The temporary child protection supervisor should be counseled for her poor judgment in assessing the safety of two young children.

The employee received a one-day suspension.

3. The Department needs to amend or clarify Extended Family Support's Program Plan for FY09. It should allow caregivers of *children* who are not the subject of any current case to qualify for Extended Family Support services.

The Division of Service Intervention has approved the changes to Procedures. The Office of Child and Family Policy will process the revisions.

4. Extended Family Support Staff Managers should meet with Child Protection Program Managers and Supervisors to assure an efficient referral process. Training should take place once the Extended Family Support Program Plan is finalized.

The Department has drafted a Request for Proposal for a statewide Extended Family Support monitoring agency. One of the responsibilities of the contracted monitoring agency will be to provide training to DCFS staff on the Extended Family Support Program.

DEATH AND SERIOUS INJURY INVESTIGATION 13

ALLEGATION

A baby girl was delivered stillborn as a result of pre-natal substance abuse by her mother. A child protection investigation of the family had been unfounded 10 months earlier.

INVESTIGATION

The mother arrived at the hospital via ambulance after the car she had been traveling in broke down. Attending physicians recognized that the mother's placenta had ruptured significantly and performed a caesarian section, however the baby was deceased. Blood taken from the placenta was tested and returned positive results for the presence of cocaine, opiates, amphetamines and Valium. A call was made to the State Central Register (SCR) and the call was coded as "action needed" to check on the welfare of the mother's three other children, ages seven, three and ten months, however no report was taken for either the baby's death or risk of harm to the three other children. In an interview with the OIG, the SCR administrator stated that since neither a physician or medical examiner had confirmed the baby's death was drug-related at the time the hotline call was made, SCR did not have jurisdiction to open a report on the infant's death. The SCR administrator further stated that an allegation of risk of harm to the three other children would have required a demonstrated negative impact of the mother's substance use on their care. Since the father of the youngest child and the stillborn baby was present in the home and no information had been offered suggesting he was an inadequate caretaker, no report was taken for risk of harm.

Four months after the baby was delivered stillborn, the county coroner's jury inquest determined the baby's death was "without a doubt" the result of the mother's drug use during her pregnancy. Although the mother had admitted to limited pre-natal substance use, she had blamed the positive result primarily on Vicodin she had been prescribed following an automobile accident six months prior to the delivery. It was as a result of the accident the mother first learned she was pregnant. The coroner's jury found that the level of cocaine present in the baby's system meant the mother had ingested the drug the day the baby was delivered. The jury concluded the mother's substance abuse caused her placenta to rupture, resulting in the death. The baby's father later admitted to law enforcement he was aware of the mother's cocaine and methamphetamine use while she was pregnant. The father stated he often engaged in using the drugs along with the mother and made no effort to persuade her to stop or obtain other assistance for her.

The OIG found SCR does not have a consistent policy for accepting reports of drug use by pregnant mothers who have other children present in their homes. Drug use by a pregnant mother represents a substance abuse problem of such magnitude that it should immediately raise concerns regarding the mother's ability to provide care for any children and the environment in which those children live.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The SCR Administrator should issue a policy memo instructing SCR operators that when a mother delivers a stillborn (20 weeks gestation or more) and either the mother or the placenta tests positive for illegal substances, SCR should immediately initiate an investigation for death by abuse. In addition, SCR should take for investigation an allegation of risk of harm to any children in the home.

The Memo was issued but the DCFS Office of Legal Services requested that the memo be rescinded until the allegation system is amended, which is in progress.

DEATH AND SERIOUS INJURY INVESTIGATION 14

ALLEGATION

A baby born three months premature died minutes after being delivered. The mother, who tested positive for drugs and alcohol at the time of the birth, had been the subject of an indicated report three weeks earlier.

INVESTIGATION

The family's involvement with the Department began after the hotline received a call alleging the mother's substance abuse issues placed her nine month-old son at risk. As a result of staffing shortages and schedule changes, the assigned child protection investigator did not meet with the family until three weeks after the initial report was made. The investigator observed the infant at the home of his grandmother, who had taken custody of the child because of her concerns about his mother's lifestyle. The grandmother stated the mother had developed a crack addiction and was unable to care for herself or her son. The grandmother described a recent trip to the mother's home when she attempted to return the boy after a visit. The grandmother said she entered the home through an open door and found the house in a state of extreme disarray. The grandmother then located the mother in a bedroom, naked and incapacitated with mud covering her feet. The mother was incoherent and unable to maintain consciousness, prompting the grandmother to take the boy back home with her.

Two weeks later the investigator returned to the grandmother's home and interviewed the mother, who admitted she had started smoking crack approximately 18 months earlier and said she continued to do so once a week. The mother also informed the investigator that she was five months pregnant and had not sought or received any prenatal care. She agreed to participate in substance abuse services and expressed her desire that her son remain with his grandmother, as she was about to be evicted from her residence. The investigator completed a substance abuse screen and provided the mother with a referral to a private agency to begin participation in a substance abuse program. The investigator did not contact the agency to set up the initial appointment as required by the Department's Substance Affected Family Protocol. The investigator informed the mother that if her baby tested positive for illicit substances upon birth, another hotline report would be generated. Three weeks later the mother delivered the baby at six months gestation. The infant tested positive for cocaine, opiates and alcohol and died minutes after being born.

In an interview with the OIG, the investigator stated the mother was provided with a referral to a private agency in her community rather than intact family services because she was not caring for her son at the time and he was not present in her home. The investigator also said he did not consider referring the grandmother to probate court to assume guardianship of the boy because the grandmother did not wish to permanently remove the child from his mother care. In a separate interview, the child protection investigator's supervisor supported the investigator's decisions to utilize community resources rather than intact services and not to pursue guardianship. Both the investigator and his supervisor stated they were unfamiliar with the Substance Affected Family Policy. As such, they were unable to explore all potential options for providing services to the family. In addition, neither the investigator nor his supervisor were aware of the possibility of screening the case into court for short-term guardianship, which would have placed greater requirements upon the mother and provided the grandmother access to additional support and services.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Division of Service Intervention should meet with management to address targeted training on the Substance Affected Family Policy, Procedure 302, Appendix A (2006) and the use of short-term guardianship.

The Department agrees. The Division of Service Intervention will meet with the Division of Child Protection Management to develop and implement a training. DCFS Investigative and Intact staff will be trained in all the Cook Regions beginning in December 2008.

2. The child protection investigator should be counseled for failure to secure appropriate drug treatment through the DASA initiative given the high risk variables in this case.

The investigator received non-disciplinary counseling.

3. The child protection supervisor should be counseled for failure to secure appropriate drug treatment through the DASA initiative given the high risk variables in this case.

The supervisor received a 3 day actual suspension and a two day paper suspension.

DEATH AND SERIOUS INJURY INVESTIGATION 15

ALLEGATION

An 11 month-old girl died in a fire at the home of her foster parents. The baby had been involved with the Department since her birth.

INVESTIGATION

The mother's family had a history of involvement with the Department dating back to when she was 10 years-old. As a teen, she had given birth to three children who were later removed from her custody. The children were placed in the relative foster home of the paternal aunt and uncle of one of the children. After the mother's parental rights were terminated the aunt and uncle adopted all three children. Following the birth of the mother's youngest child, the baby girl was removed from her custody and initially resided with another relative before being placed with the aunt and uncle in a relative foster care placement. The baby girl moved into the couple's home seven months prior to the fire.

Although the foster parent license for the aunt and uncle's home was overseen by a private agency, a second private agency was responsible for handling the baby's case and placing her in the home. The licensing agency approved the placement but did not notify its staff or ensure that a copy of the placement approval was in the case file. The licensing worker from the licensing agency was never contacted regarding the baby's placement in the home. Department Procedure requires that when a private agency seeks to place a child in a foster home licensed through another agency, the licensing worker must conduct a visit to the home with the assigned worker from the agency placing the child. The licensing worker and his supervisor, and the placement worker and her supervisor, all told the OIG they were unaware of the requirement for a joint home visit under such circumstances. The OIG found that while the rule had been amended almost two years earlier and was available for review on the Department's website, the version available for download did not include the change.

During the course of the investigation it was learned the aunt and uncle had moved to another home since initially becoming foster parents but had not filed a new license application for the new address. The licensing worker stated he had provided the necessary forms to the couple on more than one occasion but they had not been returned. The placement worker told the OIG she did not know the aunt and uncle's foster home was out of compliance with licensure when she placed the baby in the home.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. In cases of a shared home, the Pre-placement Questionnaire (CFS 2012) should instruct workers to complete the form with the licensing worker present prior to contacting placement clearance.

The form (CFS 2012) was revised.

2. The requirement outlined in Procedures 301, Appendix E: Placement Clearance Process regarding a joint-site-visit between the licensing worker and placing worker should be included in licensing procedures.

The Department agrees. Procedures 402, Licensing Standards For Foster Family Homes, has been revised to indicate that a joint on-site visit to the foster home may be required by the licensing worker and placement worker to complete the CFS 2012, Pre-Placement Questionnaire. The revised Procedures 402 has been sent to the Director for approval.

3. In compliance with Rule 383.90(e), the private agency holding the aunt and uncle's foster home license should immediately give notification to the couple instructing them to complete the application for address change or their foster home license will be deemed surrendered.

The foster home license has expired.

4. The Office of Child and Family Policy should ensure that policy changes are updated in both the online and downloadable formats.

The Department agrees. The Office of Child and Family Policy will ensure that policy revisions for the On-line Reference and Downloads sections of the Web Resource will be updated simultaneously.

CHILD DEATH REPORT

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

Notification of a child's death initiates a preliminary investigation in which the death report is reviewed, databases are searched and results reviewed, autopsy reports are requested, and a chronology of the child's life, when available, is reviewed. The next level of investigation is an investigatory review of records in which records may be impounded, subpoenaed, or requested, and reviewed. When warranted, OIG investigators conduct a full investigation, including interviews. A full investigation usually results in a report to the Director of DCFS. The majority of cases are investigatory reviews of records, often including social service, medical, police and school records, in addition to records generated by the Department.

Cases, individually, may not rise to a level necessitating a full investigation, but collectively can indicate systemic patterns or problems that require attention. The OIG continues to address systemic issues through a variety of means, including cluster reports, initiatives, and trainings. Systemic issues previously addressed include: substance abuse, infant sleep safety, and home safety. This past year, the OIG commenced Error Reduction Training for child protection investigations of cuts, bruises and welts after noting that a number of children's deaths were preceded by an unfounded or pending investigation involving an allegation of cuts, bruises and welts. The OIG is continuing Error Reduction efforts in the current fiscal year by developing evidence-based practice protocols and trainings to improve services to substance-affected and mentally ill parents.

In Fiscal Year 2008 the OIG investigated **99** child deaths meeting criteria for review, a decrease from 111 deaths in FY 2007, but an increase from 86 deaths in FY 2006. A description of each child's death and DCFS involvement is included in the annual report for the fiscal year in which the child died. This year's annual report includes summary information for children who died between July 1, 2007 and June 30, 2008. During this fiscal year, preliminary investigations were conducted in **5** cases; investigatory reviews of records were conducted in **69** cases; full investigations were opened in **25** cases: **13** investigations have been completed, with **11** reports to the Director; and **12** investigations are pending. Comprehensive

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

[3] Since the implementation of SACWIS, some investigations are expunged from the system in less than a year. Therefore, not all child deaths actually meeting the criteria for review are brought to the attention of the OIG.

summaries of death investigations reported to the Director in FY 08 are included in the Investigations section of this annual report.

SUMMARY

Following is a statistical summary of the 99 child deaths investigated by the OIG in FY 08, as well as summaries of the individual cases. The first part of the summary presents child deaths by age and manner of death, case status and manner of death, county and manner of death, and substance exposure status and manner of death. The second part presents a summary of deaths classified in five manners: homicide, suicide, undetermined, accident, and natural. [4]

Key for Case Status at the time of OIG investigation:

Ward . . . . . ….. Deceased was a ward

Unfounded DCP . . . . . …… Family had an unfounded DCP investigation within a year of child's death

Pending DCP . . . . . …... Family was involved in a pending DCP investigation at time of child's death

Indicated DCP . . . . . …... Family had an indicated DCP investigation within a year of child's death

Child of Ward . . . . . …… Deceased was a ward's child, but not a ward themselves

Open/Closed Intact . . . . . …….. Family had an open intact family case at time of child's death / or within a year of child's death

Open Placement . . . . . … ….. Deceased, who never went home from hospital, had sibling(s) in foster care

Split Custody . . . . . ……. Deceased, who was at home with family, had sibling(s) in foster care (or out of home pursuant to a DCFS safety plan)

Preventive Services . . . . . …... Intact family case was opened to assist family, but not as a result of an indicated DCP investigation

Return Home . . . . . ……. Deceased or sibling(s) was returned home to parent(s) from foster care within a year of child's death

Child Welfare Services Referral…... A request was made for DCFS to provide services, but no abuse or neglect was alleged

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

Table 1: Child Deaths by Age and Manner of Death

Child Age		Homicide	Suicide	Undetermined	Accident	Natural	Total
Months of Age	At birth	1				6	7
	0 to 3	2		5	7	7	21
	4 to 6	2		3	2	2	9
	7 to 11	2		1	1	4	8
	12 to 24	3				4	7
Year of Age	2	3		1	1	3	8
	3	1			2	2	5
	4				1	1	2
	6					1	1
	7	1			1	1	3
	9				1		1
	10	1			1		2
	11					1	1
	12				1		1
	13	1	1	1		1	4
	14				2	2	4
	15		2		1	1	4
	16	1	1			3	5
	17	1		1	1		3
	18 or older				1	2	3
TOTAL		**19**	**4**	**12**	**23**	**41**	**99**

Table 2: Child Deaths by Case Status and Manner of Death

Reason for OIG investigation*		Homicide	Suicide	Undetermined	Accident	Natural	Total
DCP	Pending	3	2	4	1	3	**13**
	Unfounded	3	1	1	7	6	**18**
	Indicated	4		2	2	4	**12**
Ward		3			5	11	**19**
Former Ward					1		**1**
Return Home					1		**1**
Open Placement						3	**3**
Open Intact		4	1	3	4	6	**18**
Closed Intact						2	**2**
Split custody						1	**1**
Child of Ward		1			1	1	**3**
Preventive Services/Extended Family						3	**3**
Child Welfare Services Referral		1		2	1	1	**5**
TOTAL		**19**	**4**	**12**	**23**	**41**	**99**

* This was the primary reason for OIG investigation.

Table 3: Child Deaths by County of Residence and Manner of Death

County**	Homicide	Suicide	Undetermined	Accident	Natural	TOTAL
Adams			1			**1**
Cook	10	3	8	10	20	**51**
DuPage				1		**1**
Effingham					1	**1**
Jackson					1	**1**
Lake	1			2		**3**
Macon			1	1	3	**5**
Macoupin					1	**1**
Madison	2			1	5	**8**
Massac			1			**1**
McHenry	1					**1**
McLean	1			1	1	**3**
Monroe	1					**1**
Montgomery		1				**1**
Peoria				2	1	**3**
St. Clair	2				2	**4**
Saline	1					**1**
Sangamon				1	2	**3**
Stephenson					1	**1**
Will					3	**3**
Winnebago			1	4		**5**
TOTAL	**19**	**4**	**12**	**23**	**41**	**99**

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

Table 4: Child Death by Substance Exposure and Manner of Death

Substance exposure	Homicide	Undetermined	Accident	Natural	TOTAL
Child exposed at birth***	2	3	1	11	**17**
Mother has history of substance abuse	1	1	1	3	**6**

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

FY 2008 DEATH CLASSIFICATION BY MANNER OF DEATH

HOMICIDE

Nineteen (19) deaths were classified homicide in manner.

CAUSE OF DEATH	NUMBER
Abusive head trauma	8
Multiple Injury due to child abuse	5
Suffocation/Asphyxia/Strangulation	2
Complications of maternal drug use	1
Gunshot wound	1
Neglect	1
Stab Wound	1
TOTAL	**19**

Perpetrator information:

PERPETRATOR	NUMBER*
Father	6
Mother	8
Mother's Boyfriend	3
Unrelated Peer	3
Babysitter	1
Brother	1
Father's Girlfriend	1
Step-father	1
Unrelated Adult	1
Unknown/Unsolved	1

* In four deaths, there was more than one perpetrator.

PERPETRATOR SEX	PERPETRATOR AGE RANGE	CHARGES*
15 Males	14-31	13 are charged with 1st degree murder, all are awaiting trial
10 Females	21-42	8 are charged with 1st degree murder, all are awaiting trial

* There were no charges in five deaths (one unknown perpetrator).

SUICIDE

Four (4) deaths were ruled suicide.

Three children had a cause of death of hanging.
One child had a cause of death as gunshot wound.

UNDETERMINED

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

Twelve (12) deaths were classified undetermined in manner.

9 children had an undetermined cause.
2 children had a cause of Sudden Unexplained Death in Infancy.
1 child had a cause of carbon monoxide intoxication due to inhalation of smoke and soot due to apartment fire.

ACCIDENT:

Twenty-three (23) deaths were classified accident in manner.

CAUSE OF DEATH	NUMBER
Asphyxia/sleep related deaths	9
Auto/Train Striking pedestrian	3
Drowning	3
Motor vehicle related deaths	3
Fire related deaths	2
Aspiration of foreign object	1
Blunt trauma due to gate crushing	1
Drug Overdose	1
TOTAL	**23**

NATURAL:

Forty-one (41) deaths were classified natural in manner.

CAUSE OF DEATH	NUMBER
Cerebral Palsy	7
Complications from premature birth	5
Pneumonia or respiratory illness (including asthma)	5
Intrauterine Fetal Demise/Stillbirth	4
Sudden Infant Death Syndrome (SIDS)	4
Cardiac disease or complications from heart problems	2
Metabolic Disorders	2
Seizure Disorder	2
Bacterial Meningitis	1
Cancer	1
Complications of Sickle Cell Anemia	1
Cystic fibrosis	1
Dehydration	1
Diabetic Ketoacidosis	1
Meningococcemia	1
Muscular dystrophy	1
Multiple medical problems	1
Osteogenesis Imperfecta	1
TOTAL	**41**

HOMICIDE

Child No. 1	DOB 3/89	DOD 1/07; Identified 1/08	Homicide
Age at death:	17 years old		
Substance exposed:	No		
Cause of death:	Asphyxia, with multiple blunt force injuries significantly contributing to death		
Perpetrator:	Unknown		
Reason For Review:	Teenager was a ward		
Action Taken:	Investigatory review of records		

Narrative: In January 2007 the deceased's body was found stuffed inside a cardboard box in a garbage bin in an alley. The girl was not identifiable by fingerprints or a disseminated sketch of her face which was disfigured. With the help of America's Most Wanted, a clay model was made of the girl's face and a sketch of the model was disseminated in the Illinois Dental News with the hope that her orthodontist would recognize her because she had extensive orthodontic work completed. A receptionist at an orthodontist's office recognized the girl and alerted the orthodontist who contacted police. Dental records confirmed the girl's identity. She was a DCFS ward who had been reported missing eight months before her body was discovered. To date, a perpetrator has not been identified.

Prior History: The deceased entered foster care toward the end of 2003 after her 35-year-old mother left her in the care of a neighbor for 2 weeks without contacting her and without ensuring she had necessary medication. The mother was indicated for inadequate supervision and abandonment. Between the ages of 2 and 10, the child had lived with a maternal aunt by private agreement, but the mother took her back. After she entered foster care, the aunt, who had developed health problems, was unable to care for her. The girl had numerous placements, some from which she ran. In May 2006 the girl left her placement for school and never returned. The girl never contacted her worker and her last communication with family members was in June 2006. DCFS made numerous attempts to locate the girl including speaking with family members and friends, filing a missing persons report with police, and contacting the National Center for Missing and Exploited Children. In addition, the court overseeing the girl's wardship issued a child protection warrant for her.

Child No. 2	DOB 3/94	DOD 7/07	Homicide
Age at death:	13 years old		
Substance exposed:	No		
Cause of death:	Multiple injuries due to child abuse		
Perpetrator:	Mother and stepfather		
Reason For Review:	Open intact family case within a year of child's death		
Action Taken:	Full investigation; report to Director 5/19/08		

Narrative: Thirteen-year-old developmentally delayed child was taken by ambulance to the emergency room after allegedly suffering a seizure. The child had multiple injuries and appeared to have been beaten. An autopsy revealed internal hemorrhaging and cachexia (physical wasting with loss of weight and muscle mass). The child's 34 year old mother and 31-year-old step-father were charged with first-degree murder. The State is seeking the death penalty.

Prior History: This family has a history of involvement with DCFS dating to 1994 when at 3 months of age, the deceased and her twin brother were discovered to have abusive head injuries and rib fractures. Their six-year-old half-brother showed no signs of abuse. The twins' parents were indicated for abuse and all three children entered foster care. After participating in services, the mother regained custody of her children in January 1998. She and the children participated in aftercare services under court supervision for three years. The family's court case was closed in February 2001, and the DCFS case was closed in August 2001. Between January 2000 and February 2006, there were five DCP investigations; all were unfounded. In March 2006, an "unknown perpetrator" was indicated for a fractured clavicle to the deceased. The mother and stepfather were indicated for substantial risk of physical injury, and an intact family case was opened. The parents appealed the indicted finding and the Department, after legal review, withdrew the indicated finding. The intact family case remained open through February 2007. Another DCP investigation was unfounded during that time. See Death and Serious Injury Investigation # 4.

Child No. 3	**DOB 2/07**	**DOD 7/07**	**Homicide**
Age at death:	4-1/2 months old		
Substance exposed:	No		
Cause of death:	Multiple injuries due to blunt trauma due to child abuse		
Perpetrator:	Mother's boyfriend		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Full investigation; report to Director 5/15/08		

Narrative: Four-and-a-half-month-old infant was admitted to the hospital with diffuse brain swelling, a subdural hematoma, a fractured clavicle, healing rib fractures, and possible bilateral retinal hemorrhages. The infant died from her injuries three days later. Her 17-year-old mother's boyfriend said he was playing a video game while holding the infant and when he jumped up in frustration, she fell off his lap and went limp. He panicked and shook her. The 21-year-old boyfriend has been charged with first-degree murder. He was indicated for abuse in the child's death. The mother was indicated for neglect.

Prior History: Two months earlier, a hospital called the hotline reporting that the maternal grandmother brought her 3-month-old grandchild to the emergency room with a bruise on her face and a bruise (later identified as a possible bite mark) to her shoulder. After seeing the infant and speaking with the mother and maternal grandmother, the investigator assessed the infant as safe and instructed the grandmother to return the infant to her mother. The child's doctor reported that the infant had previously had a bruise on her forehead which the "father" said was from the infant hitting her head on the crib. An intact family case was going to be opened. At the time of the infant's death, the investigation of the bruising was still pending, but not actively being worked on. There were staff shortages in the field office at the time of this investigation. See Death and Serious Injury Investigation # 1.

Child No. 4	**DOB 8/05**	**DOD 8/07**	**Homicide**
Age at death:	23 months old		
Substance exposed:	No		
Cause of death:	Blunt head trauma due to assault		
Perpetrator:	Mother's roommate		
Reason For Review:	Unfounded DCP investigation within a year of child's death & Indicated DCP investigation within a year of child's death		
Action Taken:	Full investigation, report to Director 6/25/08		

Narrative: Twenty-three-month-old child was allegedly shaken and thrown to the floor by her mother's roommate, who was babysitting the child. The roommate/babysitter has been charged with first-degree murder and is awaiting trial. She was indicated for death and head injuries by abuse and substantial risk of physical injury to her 11-year-old twins, who are now in foster care. The deceased was an only child. The child's mother was indicated for death and head injuries by neglect because she left her child in the roommate's care after she agreed in a previous investigation not to use the roommate for child care.

Prior History: In the year prior to the child's death, the roommate was the subject of two separate investigations, one involving the deceased and one involving a 12-month-old child she was babysitting. In the first investigation, in February 2007, the roommate was investigated for suspicious bruising to the deceased's face which occurred while the roommate was babysitting the child. The father, who shared custody of the child, saw the bruising and immediately took the child to the hospital. The investigation was unfounded. One month after the first investigation was unfounded, a second report was made because of facial bruising and head injury to a twelve-month-old girl who was being babysat by the roommate. The roommate claimed to not know how the injury occurred because she was in another room on the phone. She was indicated for head injuries by neglect and inadequate supervision. The roommate agreed not to babysit anymore, and the deceased's mother said she would find alternate childcare. See Death and Serious Injury Investigation #3.

Child No. 5	DOB 1/07	DOD 8/07	Homicide
Age at death:	7 months old		
Substance exposed:	No		
Cause of death:	Blunt force trauma to the head		
Perpetrator:	Mother's boyfriend		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Seven-month-old infant was found unresponsive by his 20-year-old mother in the early morning. The mother had left the baby in the care of her 18-year-old boyfriend the night before while she was at work. While watching the baby, the boyfriend threw the baby against a wall or furniture causing blunt force trauma to his head. The mother said her boyfriend sent her a text during the evening saying the baby had fallen off a couch and hit his head on a table. She checked on the baby when she got home, and he appeared fine. The autopsy revealed that the infant had an older, iron shaped burn on his back for which he had not received medical treatment. The mother initially claimed to have caused the burn to take suspicion off her boyfriend, but he took responsibility for it, claiming he accidentally burned the infant while ironing. The mother had known the boyfriend for two years, but had been dating him for only four months. The boyfriend was charged with first degree murder and is in jail awaiting trial. The mother believes her boyfriend accidentally killed her child. The mother has been uncooperative with the DCFS death investigation, which is still pending.

Prior History: Six months earlier, a 15-year-old mother left her two-month-old baby with the baby's father (the alleged perpetrator above) for the night. When she picked up the baby the next morning, she found bruises on the baby's legs and buttocks. She confronted the baby's father, who said he accidentally hit the baby with a belt when he was whipping his dog. When the teen mother returned home and the maternal grandmother saw the bruises, the grandmother called the police and took the baby to the hospital. The infant had earlier suffered a bite mark while in the father's care, and the maternal grandmother and mother had gotten into an argument over the mother allowing the father to take the infant again. The father was indicated for cuts, bruises, welts to the infant. The mother and maternal grandmother agreed that the father would not be left alone with the baby again. Police declined to charge the father with a crime, later stating that there had been insufficient evidence to support a charge.

Child No. 6	DOB 10/06	DOD 10/07	Homicide
Age at death:	20 months old		
Substance exposed:	No		
Cause of death:	Cerebral injuries due to blunt trauma of the head		
Perpetrator:	Mother's boyfriend		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twenty-month-old infant was taken to the hospital with severe head injuries that his mother reported occurred when he hit his head on a coffee table and had a seizure. The child was transferred to another hospital's intensive care unit where he died the following day. The child's injuries were extensive and determined to be from non-accidental trauma. The child's mother's 23-year-old boyfriend was indicated for death by abuse and the 27-year-old mother was indicated for substantial risk of physical injury to the deceased and his 6-year-old sibling for leaving them in the boyfriend's care despite other recent, unexplained injuries to the deceased while in the boyfriend's care. The boyfriend was also indicated for substantial risk of physical injury to his 5-year-old child with another woman. In September 2008 the boyfriend was charged with first degree murder. Following the death, the mother's surviving child was placed in foster care where she remained until June 2008 when she was placed with her mother under court supervision.

Prior History: In May 2007 the hotline was called with an allegation of substantial risk of physical injury to the deceased and his older sister because the mother's 26-year-old boyfriend was arrested for grabbing the mother during an argument. Both parties reported that they were breaking up and the boyfriend went to the mother's home to pick up some of his things, and they got into an argument that got physical. The mother called police. Police verified that the children were never at risk because they were asleep in their rooms. The investigation was unfounded.

Child No. 7	DOB 8/06	DOD 10/07	Homicide
Age at death:	14 months old		
Substance exposed:	No		
Cause of death:	Dehydration due to parental neglect		
Perpetrator:	Mother		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twenty-four-year-old mother called 911 stating her child had stopped breathing. Emergency personnel responded. The mother reported that she had fed the child and then she stopped breathing. The baby had been dead for longer than the mother reported. The mother was charged with murder in April 2008 after the child's death was ruled a homicide. The mother's 2-year-old child was placed in foster care where he remains.

Prior History: The child was born 3-1/2 months prematurely and spent the first 4 months of her life in the hospital. In December 2006, the hospital called DCFS with concerns that the mother only visited the child sporadically, minimally attended training to care for the child, and did not seem to comprehend the seriousness of the child's need for weekly medical appointments for a retinal abnormality. An investigation for substantial risk of physical injury was unfounded, but an intact family case was opened and the child was released to her mother's care. A month later, the child was hospitalized because of weight loss and the hotline was contacted again. The mother was indicated for failure to thrive. The mother lived with her grandfather and teenaged siblings, who helped her care for her children. At the time of her death, the child was being seen by a public health nurse, early intervention providers, and a homemaker. The intact family worker was in contact with the providers and also saw the mother and her children in their home at least twice monthly.

Child No. 8	DOB 3/97	DOD 10/07	Homicide
Age at death:	10 years old		
Substance exposed:	No		
Cause of death:	Multiple gun shot wounds		
Perpetrator:	Three unrelated teenagers		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Ten-year-old boy was walking to a corner store with a friend at approximately 4:30 p.m. when he was killed by stray bullets from an altercation between rival gang members. Multiple shots were fired and the boy was struck a couple of times in the neck and heel. Two 17-year-old boys and a 14-year-old boy have been charged in his death. The 17-year-olds are being tried as adults and the 14-year-old will be tried as a juvenile.

Prior History: The deceased's 38-year-old mother has given birth to ten children; four of them were born substance-exposed. She has had three intact family cases opened and closed since 1996. In February 2007, she gave birth to her third substance-exposed child and her fourth intact family case was opened. The case was open at the time of the 10-year-old's death. In June 2008, when the mother gave birth to her fourth substance-exposed child, her eight minor children entered foster care. They are placed with relatives.

Child No. 9	DOB 10/07	DOD 10/07	Homicide
Age at death:	0		
Substance exposed:	Yes, opiates, cocaine, amphetamines, and valium		
Cause of death:	Stillborn death secondary to abruptio placenta complications due to maternal cocaine and amphetamine use		
Perpetrator:	Mother		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation, report to Director 6/25/08		

Narrative: Twenty-five-year-old mother delivered her fourth child stillborn at approximately 35 weeks gestation. She had previously had two miscarriages and had a twin fetus die in utero. The stillbirth was the result of placenta abruptia which is often caused by drug use. Blood taken from the placenta tested positive for opiates, cocaine, amphetamines, and valium. Despite having 7-year-old, 3-year-old, and 10-month-old children at home, and not knowing who was caring for them, a report was not taken by the State Central Register for investigation of the child's death or substantial risk of physical injury to the mother's three living children until four months later when a coroner's jury ruled the death a homicide.

Prior History: In December 2006, while she was in the hospital giving birth to her third child, the mother mentioned to a nurse that her live-in boyfriend, the father of the newborn, was a registered sex offender. The hotline was called with a report of substantial risk of sexual abuse to the newborn and her two older siblings. The report was unfounded after it was determined that the father did not pose a risk to the children. The incident leading to his registration had occurred seven years earlier with a 19-year-old girlfriend when he was 17. The father told the investigator that he did not realize that by making a plea to get out of jail, it meant he was labeling himself a sexual offender. The father had complied with registration and had only three more years to register. He had been honest with his girlfriend about his past. See Death and Serious Injury Investigation #13.

Child No. 10	DOB 6/00	DOD 11/07	Homicide
Age at death:	7 years old		
Substance exposed:	No		
Cause of death:	Aspiration pneumonia due to sequelae (after-effect) of remote closed head injury		
Perpetrator:	Father		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Seven-year-old medically complex ward exhibited flu-like symptoms. On the second day, she began to have trouble breathing, and her foster father called 911. While the ambulance was en route, the ward stopped breathing. The foster father performed CPR and got the child breathing, but she stopped again prior to the ambulance arriving. Attempts to revive her were made, but failed. The seven year old's death was attributed to the injuries that brought her into care five years earlier. The biological father was charged with murder and is awaiting trial.

Prior History: The ward was medically complex as a result of abuse she suffered at the age of 2 by her 23-year-old father. He shook her and threw her up in the air, letting her drop to the floor. The 19-year-old mother was present, but did not take the infant to the hospital. It was not until an uncle observed the baby foaming at the mouth with her eyes rolling back in her head that medical care was sought. The infant's diagnoses included shaken baby syndrome, cerebral palsy, severe mental retardation, seizure disorder, and cortical blindness. She required a G-tube for feeding and had several hours of in home nursing services several times a week. The father was convicted of aggravated battery to a child and is serving a 9-year-sentence. He was indicated for abuse to the child and the mother was indicted for medical neglect. They were both indicated for substantial risk of physical injury to the injured child and her 4-year-old sibling. The deceased had lived in her current foster home for a little over a year. Her surviving sibling is in a pre-adoptive foster home.

Child No. 11	DOB 6/05	DOD 12/07	Homicide
Age at death:	2-1/2 years old		
Substance exposed:	No		
Cause of death:	Multiple injuries due to blunt trauma due to child abuse		
Perpetrator:	Mother		
Reason For Review:	Open preventive services case at time of child's death		
Action Taken:	Full investigation pending		

Narrative: Two-and-a-half-year-old child was discovered by his 21-year-old father having trouble breathing at approximately 1:30 in the morning when the father returned home from work and checked on the children. The mother and father took him to the hospital where his condition was so poor, he was transferred to a children's hospital. The 24-year-old mother reported that the child, who appeared to have been beaten, had jumped from a bunk bed the day before and had been lethargic. The child died later that day. His mother was charged with first degree murder.

Prior History: The mother was a ward of DCFS from the ages of eight to twenty-one. At 13 years old, she gave birth to her first child. She has given birth to ten children; one of the children was reported to be the product of rape and was given up for adoption at birth. The three oldest children lived with relatives. The deceased was born with congenital heart disease, had trouble feeding, and failed to gain weight. He remained hospitalized for three months. When he was ready for discharge, the mother was living in a homeless shelter, so the hospital made arrangements for the infant to be placed in a nursing care facility. In March 2006, the mother called a local child welfare agency to report that she was homeless and could not keep her children. The agency placed the children in voluntary foster care, and an intact family case was opened to help stabilize the family. The deceased remained in his nursing care facility. His mother did not visit regularly, and staff were concerned about her ability to care for him and provide an appropriate environment. He was released to her care two months prior to his death, in October 2007.

Child No. 12	**DOB 8/05**	**DOD 12/07**	**Homicide**
Age at death:	2 years old		
Substance exposed:	No		
Cause of death:	Closed head injury		
Perpetrator:	Mother, father, and father's girlfriend have been charged		
Reason For Review:	Indicated and unfounded DCP investigations within a year of child's death		
Action Taken:	Full investigation pending		

Narrative: Two-year-old child's 24-year-old mother reportedly took the child to his 23-year-old father's home to be cared for while she went out. The father's 26-year-old girlfriend said that after the child was put to bed for the night, she heard him coughing, went to check on him, and discovered he had stopped breathing. She called the child's mother who came and picked the child up and took him to the hospital where he was pronounced dead. His body was covered in bruises. None of the three caregivers ever called 911. The mother, father, and father's girlfriend have all been charged with first degree murder. Four surviving children of the parents are in foster care.

Prior History: In November 2006 and June 2007, reports were made to the hotline alleging substantial risk of physical injury to the girlfriend's 6-year-old daughter by the deceased's father. Both investigations were unfounded. In September 2007, the hotline was called after the deceased's mother took him to the emergency room with numerous bruises and bite marks. The mother had just picked up the child from a visit with his father. The investigator learned that the child had returned home from visiting his father previously with injuries, but the mother always thought the explanations were plausible. The mother had also been beaten by the father prior to getting pregnant with the deceased. The father refused to be interviewed during the investigation. The injuries were attributed to the deceased's 1-1/2 and 2-1/2 year-old half-siblings, and the father was indicated for inadequate supervision and human bites by neglect. The mother said she was not going to allow contact between the child and his father anymore. No service case was opened in either household.

Child No. 13	**DOB 12/07**	**DOD 12/07**	**Homicide**
Age at death:	1 month old		
Substance exposed:	Unknown		
Cause of death:	Craniocerebral injuries due to blunt head trauma		
Perpetrator:	Father		
Reason For Review:	Child welfare services referral within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: One-month-old infant was slammed on the bed and shaken repeatedly by her 28-year-old father. The child, who lived in Indiana with her mother, was being cared for by her father for the weekend. The father has been charged with first degree murder.

Prior History: In January 2006, the father called the hotline requesting assistance in obtaining an apartment and filing for public aid benefits for his 2-1/2 year old daughter with another woman. The father said that the child had been living with her mother in Oklahoma, but the mother dropped her off at the father's home. The father wished to care for the child, but he lived with his mother, who was unwilling to let him stay there with the child. A child welfare services referral was made, and an intake appointment was scheduled. The child was not present at the worker's first visit, so a second visit was scheduled. At the second visit, the father reported that the child was residing with her aunt, and he no longer needed assistance.

Child No. 14	DOB 6/07	DOD 2/08	Homicide
Age at death:	7 months old		
Substance exposed:	No		
Cause of death:	Subdural hematoma due to blunt head trauma due to child abuse		
Perpetrator:	Mother		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Full investigation pending		

Narrative: Seven-month-old baby was taken by ambulance to the hospital in full cardiac arrest at 8 a.m. Efforts to resuscitate him were unsuccessful. The infant's 24-year-old mother admitted to shaking him several times over a period of a week, causing brain injuries that resulted in his death. The mother was charged with first-degree murder. She was indicated for death by abuse and substantial risk of physical injury to her 4-year-old child. The 27-year-old father was also indicated for substantial risk of physical injury because he left the children alone with their mother in spite of her history of risk to her children**.** The 4-year-old is in foster care with her maternal grandparents.

Prior History: In October 2007, the deceased, then 3-1/2 months old, suffered a fractured femur that the parents said occurred when his 3-1/2-year-old sibling accidentally stepped on his leg. The treating orthopedic surgeon opined that the parents' history of the fracture was inconsistent with the injury. The investigation was indicated against both parents for bone fractures by abuse. An intact family case was supposed to have been opened, but a case hand-off never occurred.

Child No. 15	DOB 11/07	DOD 2/08	Homicide
Age at death:	2-1/2 months old		
Substance exposed:	No		
Cause of death:	Blunt trauma due to child abuse		
Perpetrator:	Father		
Reason For Review:	Pending DCP investigation and open intact family case at the time of the infant's death		
Action Taken:	Full investigation, no report to Director (Discipline implemented by Department)		

Narrative: Two-and-a-half-month-old infant was taken to the hospital by her 18-year-old father. She had head injuries. She was transferred to another hospital where she died the next day. The father has been charged with aggravated domestic battery and aggravated battery of a child. He is being indicated for death by abuse, and the infant's mother and maternal grandmother are being indicated for death by neglect for failing to follow a safety plan that was in place.

Prior History: Three weeks prior to the infant's death, the hotline was called by a hospital where the infant had been taken because of continuous crying. The infant was discovered to have multiple injuries, including bruises, two rib fractures, a femur fracture, and a tibia fracture. While the infant's injuries were being investigated by police and DCFS, the Department instituted a safety plan that the maternal grandmother would be the primary caretaker for the child, the 17-year-old mother would have only supervised contact with the infant, and the father would have no contact with the infant. An intact family case was opened ten days prior to the infant's death, while the investigation was pending. During the course of the safety plan, the maternal grandmother went away on a retreat for the weekend, leaving the infant at home with her mother and maternal aunt. The mother took the infant over to the father's home so that he could care for the infant while she went to work.

Child No. 16	DOB 5/04	DOD 3/08	Homicide
Age at death:	3-1/2 years old		
Substance exposed:	Yes, mother admitted to methamphetamine use during pregnancy		
Cause of death:	Subdural hemorrhage due to multiple systemic contusion and abrasion due to multiple trauma due to beating		
Perpetrator:	Mother and father		
Reason For Review:	Child was a ward		
Action Taken:	Full investigation pending		

Narrative: Three-and-a-half-year-old twins lived with their 34-year-old mother and 41-year-old father out of state on an Illinois court-ordered extended visit for three months. The parents reported that one of the twins had been sick for two days with a fever and vomiting. The mother said that she checked on the child at 7:15 a.m., and he appeared fine. At 11:00 a.m. the mother checked on the child again, and he looked pale and was moaning like he was in pain. She called the father who came home and gave the child some water. The mother called 911 about an hour later when the child's lips turned blue and he stopped breathing. The child was transported to the hospital, where he was found to have massive bruising and blunt head trauma. The child's twin, 1-year-old half-sibling (conceived while the father was in prison), and 1-month-old sibling were taken into custody and evaluated at the emergency room. The 3-1/2-year-old surviving twin had various bruises, including a black eye; the 1-year-old had a head contusion; and the 1-month-old had a bruise on his leg. The surviving twin was returned to Illinois foster care, and the two younger children entered foster care in the neighboring state. Both parents were charged with murder and are in jail awaiting trial.

Prior History: In July 2004, police took protective custody of the two-month-old twins and their 1 and 2-year-old siblings because the parents were arrested for producing methamphetamines in their home. All four children were placed in foster care, and the parents were indicated for substantial risk of physical injury and environmental neglect. Both parents were convicted and spent time in prison. Each was paroled out of state, where they cared for the mother's two youngest children. The parents minimally participated in services to regain custody of their four children in Illinois. In January 2008, the court approved sending the twins to live with their parents on an extended visit with a plan to send the two older children at a later date.

Child No. 17	DOB 1/06	DOD 4/08	Homicide
Age at death:	2 years old		
Substance exposed:	No		
Cause of death:	Anoxic brain injury due to strangulation		
Perpetrator	Mother or brother; open investigation		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twenty-one-year-old mother reportedly found her 2-year-old son unresponsive after the mother finished taking a shower. At the hospital, the 4-year-old sibling told medical staff that he and his brother were playing and he put Spiderman webs (a curtain sash) around his brother's neck and pulled it tight, demonstrating by closing his fists and stretching them apart. Later, he told a child victim sensitive interviewer that his mother choked his brother. The 2-year-old suffered from anoxia (lack of oxygen to the brain) and died four days later. The surviving siblings were placed under safety plans. The 4-1/2-year-old was to stay with his maternal grandmother and his 4-month-old sibling was to stay with a maternal cousin. In August 2008, the older child was returned to his mother's care because the grandmother did not want to continue the safety plan. The younger child remains under a safety plan. The State's Attorney's Office is reviewing the police investigation. An intact family case is open, but after completing some counseling sessions with her son, the mother has refused any further services.

Prior History: At the time of the 2-year-old child's death, there was a pending DCP investigation involving the deceased. In December 2007 a hospital social worker called the hotline reporting that the child had taken some oven cleaner out of a cabinet and swallowed it. The mother reported that the oven cleaner was pink, and she thought the child believed it was juice. The child was treated at the hospital and released. A report was taken for investigation of inadequate supervision and poisoning. The social worker told the investigator that she called the hotline because the mother asked about getting help with her children, not because the hospital suspected abuse or neglect. The investigator made several attempts to interview the mother, including making an appointment that the mother failed to keep. In January 2008, the investigator sent a subpoena for the mother and children's appearance, but the mother didn't comply with it. In February, the investigator asked the local police to accompany her to the home, but no one answered. In March, the supervisor instructed the investigator to staff the case with DCFS Legal. Eleven days later, the child was hospitalized and the investigator spoke to the mother at the hospital. The mother admitted to evading the investigator. The investigation was ultimately unfounded.

Child No. 18	**DOB 12/07**	**DOD 4/08**	**Homicide**
Age at death:	4 months old		
Substance exposed:	No		
Cause of death:	Multiple injuries due to blunt trauma of the abdomen due to child abuse		
Perpetrator:	Father		
Reason For Review:	Child of a ward		
Action Taken:	Full investigation pending		

Narrative: Nineteen-year-old ward claimed he awoke from a nap to find that his 4-month-old daughter was having trouble breathing. An autopsy revealed extensive internal injuries. The ward confessed in a police interview to punching his daughter 5 to 6 times because she would not stop crying. He was caring for the child while the 19-year-old mother was at work. The father has been charged with first degree murder. He was indicated for death by abuse to the infant and substantial risk of physical injury to the mother's 2-year-old child, for whom he was also caring. The mother was not indicated in the child's death, but an intact family case was opened to provide services to her and her 2-year-old child. The case remains open.

Prior History: The ward and his two siblings entered foster care in 1996 at the age of 7 when his mother went to a police station stating she was homeless and a substance abuser and needed help. One sibling was released to the guardianship of a relative in 1998 and the other was adopted in 2000. The ward, who had a history of behavioral problems lived in various residential and group home placements until June 2007 when he was allowed to "self-select" a placement so that he would stay in one place and stop running from his placements. The ward chose to live with his girlfriend and her mother. Two months prior to the infant's death, the teenagers got their own apartment. The ward's caseworker had cautioned the mother against leaving the child in the care of the father.

Child No. 19	DOB 8/91	DOD 4/08	Homicide
Age at death:	16 years old		
Substance exposed:	Unknown, mother has history of substance abuse		
Cause of death:	Stab wound of the chest		
Perpetrator:	Unrelated adult male		
Reason For Review:	Unfounded DCP investigation within a year of teenager's death		
Action Taken:	Investigatory review of records		

Narrative: Sixteen-year-old boy and his friend got into an altercation with a man coming out of a restaurant. The teenager was stabbed in the chest, and his friend was stabbed in the leg. The deceased's blood alcohol level at autopsy was .278. No other drugs were found in his system. According to police, the teenager was the initial aggressor; he started hitting the offender, who had no prior arrests. The teenager had at least 16 arrests beginning at the age of eleven for offenses such as shoplifting, armed robbery, and theft. He had a probation violation pending at the time of his death.

Prior History: The deceased and two of his siblings were adopted by their great-grandmother when the deceased was 11 years old because of a long history of neglect by their mother. The child had no more DCFS involvement until August 2007 when he was picked up after being missing since April 2007. When interviewed, the teenager reported going on run because his father and uncle were sexually abusing him. The teenager and his brother had been staying with their paternal grandmother because their great-grandmother could not handle their behavior. DCFS investigated the allegations of sexual abuse and unfounded them because of a lack of evidence.

SUICIDE

Child No. 20	DOB 3/91	DOD 11/07	Suicide
Age at death:	16 years old		
Substance exposed:	Unknown		
Cause of death:	Gunshot wound to mouth		
Reason For Review:	Pending DCP investigation at time of teenager's death		
Action Taken:	Investigatory review of records		

Narrative: Sixteen-year-old boy came up from the basement around 10:30 p.m. and walked into the kitchen waving a gun. His mother was washing dishes and his 10-year-old sister was doing her homework at the kitchen table. The teen pointed the gun at himself and his sister, who opened the refrigerator door and hid behind it because she was scared. The teen released the magazine from the gun, placed the gun in his mouth, and pulled the trigger. A bullet had remained in the chamber, killing the boy. His blood alcohol level at autopsy was .148. Police investigated. The mother reported that she thought the gun was a toy. The boy's 18-year-old twin brothers, who are gang members, reported they did not know where the gun came from. Police classified the incident as accidental.

Prior History: At the time of the teenager's death, there was a pending DCP investigation. In September, the teen was picked up by police in another town at 2:40 in the morning for violating curfew. He was intoxicated. The police called the teen's mother to come and get him. His mother did not have transportation and said she would come for her son when she was able to find a ride. When she had not arrived by 6:30 that morning, the police called the hotline. The mother arrived a few hours later. The report was ultimately unfounded for inadequate supervision. During the investigation, the teen was interviewed. He reported leaving home without his mother's permission and said that she did not know where he was. He had attended substance abuse treatment within the past year and was currently attending counseling for his behavior. After the teen's death, DCFS provided the family with referrals for grief counseling.

Child No. 21	DOB 3/94	DOD 11/07	Suicide
Age at death:	13 years old		
Substance exposed:	No		
Cause of death:	Asphyxia due to hanging		
Reason For Review:	Child welfare services referral and pending DCP investigation at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Thirteen-year-old child was found by her maternal aunt hanging by a belt in her bedroom closet. She left a suicide note.

Prior History: In October 2007, the 13-year-old child's maternal grandmother, who had been her legal guardian for five years, contacted DCFS requesting counseling services for the girl. Ten days later, the hotline was called with a report of substance misuse to the girl by her biological father, whom she had just met. Until then, she had been told another man was her father. According to the caller, the biological father had gotten the girl drunk during a visit. The investigation was indicated after the girl's death because she had admitted to drinking with her father. A second investigation was initiated when the girl told the worker responding to the request for services that she had previously been sexually molested by her mother's boyfriend. A couple of days later, the maternal grandmother told the worker that she found a note by the girl outlining 5 ways to kill yourself. Following the worker's instructions, the grandmother took the girl to the hospital where she was hospitalized for a week. She was discharged on medication and had follow-up appointments scheduled**.** The child welfare services worker and a Department of Healthcare and Family Services' SASS (Screening, Assessment and Support Services) worker met with the child on the day she hanged herself, but did not note any concerns.

Child No. 22	DOB 4/92	DOD 12/07	Suicide
Age at death:	15 years old		
Substance exposed:	No		
Cause of death:	Hanging		
Reason For Review:	Unfounded DCP investigation within a year of teenager's death		
Action Taken:	Investigatory review of records		

Narrative: Fifteen-year-old girl was found by her grandfather hanging by a belt in her bedroom closet. She left a suicide note expressing how much she loved her mother, family, and friends, but that she did not want to be a burden anymore. The teenager had a previous diagnosis for which she took medication.

Prior History: The deceased had one sibling, a 14-year-old brother who attended a therapeutic day program. Four weeks earlier, the Department investigated an allegation of substantial risk of physical injury to the 14-year-old by his 26-year-old uncle, who lived in the home. The two had been fighting over a lap top computer and pushed each other. No one was harmed. The mother and her two children lived in the maternal grandparents' home. The boy's therapeutic day program reported that the mother was compliant with treatment recommendations for her son. The deceased was interviewed during the investigation and appeared fine. The investigation was unfounded.

Child No. 23	DOB 3/92	DOD 2/08	Suicide
Age at death:	1 week shy of 16 years old		
Substance exposed:	No		
Cause of death:	Hanging		
Reason For Review:	Open intact family case within a year of teenager's death		
Action Taken:	Investigatory review of records; interim report to the Director 5/15/08		

Narrative: Teenager, one week shy of her 16th birthday, was found hanging in her bedroom closet by her stepmother. She left a suicide note. Paramedics, who responded to the child's hanging, called the hotline to report that while they were working on the teenager, they discovered a 7-year-old child sleeping in the same bed amid piles of clothing. They said the home was in deplorable condition. Subsequently, four unrelated people called the hotline reporting that the teenager had been overwhelmed being the parent to her three younger siblings and that all the children were abused and neglected. The investigation was unfounded. In May 2008, the OIG recommended that because of the documented cumulative risk to the surviving children, DCFS Legal review the records on the family and assist in screening the case with the State's Attorney's Office, for at a minimum, a protective order requiring the parents to cooperate in services. An order of protection was entered and is still in effect.

Prior History: The family has a history with DCFS dating to June 2005 when the father and step-mother were indicated for environmental neglect and referred to community services. In December 2006, an intact family case was opened after the father was indicated for cuts, bruises, welts to his 5-year-old daughter because he hit her in the face, leaving a bruise. He and the step-mother were also indicated on 3 other allegations, but they were expunged after appeal. The parents, through their attorney, refused to participate in services while their appeal was pending. In November 2007, the intact family case was closed pursuant to the parents' request. See Death and Serious Injury Investigation # 10.

UNDETERMINED

Child No. 24	DOB 2/07	DOD 7/07	Undetermined
Age at death:	5 months old		
Substance exposed:	No		
Cause of death:	Undetermined		
Reason For Review:	Child welfare services referral within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Five-month-old infant spent the night with his 17-year-old father. The baby had been taken to his father's home by his 18-year-old mother for an overnight visit. The father reported that the baby was a little congested, but otherwise seemed fine. The baby slept in bed with the father. The father awoke at 7:00 a.m., fed the baby, and went back to sleep. He awoke two hours later to find the baby unresponsive.

Prior History: Three weeks earlier, a relative called the hotline requesting child welfare services for the mother. The relative reported that the young mother was living on her own with her four-month-old baby after the relative with whom they were living, moved out of state. A worker tried to contact the mother and the maternal grandmother with phone numbers provided by the reporter and from public aid, but they were disconnected. Through another relative, the worker obtained a cell phone number for the maternal grandmother who reported the mother and child were staying with a friend. The worker tried to reach the mother at the number given to her by the maternal grandmother, but got a recording stating the customer could not receive calls. When the worker contacted the maternal grandmother again, the worker learned that the baby had died two days earlier.

Child No. 25	DOB 4/07	DOD 8/07	Undetermined
Age at death:	4 months old		
Substance exposed:	Yes, cocaine		
Cause of death:	Undetermined		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Four-month-old infant was found unresponsive by her 27-year-old mother in the morning. The mother was co-sleeping with the infant on a couch, despite having a bassinet in the home for the infant. The infant's death was undetermined because the mother did not respond to repeated attempts to conduct a scene investigation. The infant was the mother's first of two children to die within a year. Please see Child No. 33 below.

Prior History: The deceased was the mother's fourth child. She was the first to be born substance-exposed. The mother has three older children; two live with their fathers and the third lives with her godmother. The hotline was called following the infant's substance-exposed birth. The mother was indicated for substance misuse and an intact family case was opened. At the time of the baby's death, the mother was being assessed for substance abuse treatment and a public health nurse was visiting the baby.

Child No. 26	DOB 7/07	DOD 10/07	Undetermined
Age at death:	3 months old		
Substance exposed:	No		
Cause of death:	Undetermined		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Full investigation, Report to Director 6/25/08		

Narrative: Thirty-four-year-old mother took her 3-month-old infant to the hospital dead on arrival. After an autopsy, laboratory tests, and an extensive drug screen, no cause of death could be determined. A surviving 3-year-old sibling entered foster care following the infant's death. The court has set a goal of return home.

Prior History: The mother first became involved with DCFS in October 2003 when she gave birth to her first child, who was born substance-exposed. The child was adopted by parents the mother had identified while she was pregnant. Substantial risk of physical injury investigations in July 2005 and July 2006 involving the mother's second child were unfounded. In July 2007 the mother gave birth to her third child who she was considering giving up for adoption. She sought the assistance of an adoption agency and voluntarily placed the infant in a temporary home until she made up her mind. The mother decided to keep the child and a child welfare services referral was made. In September 2007 the hotline was called with a report of substantial risk of physical injury to the 2-month-old infant because of concerns about the mother's mental health. The investigation was pending at the time of the infant's death. See Death and Serious Injury Investigation # 6.

Child No. 27	**DOB 5/07**	**DOD 11/07**	**Undetermined**
Age at death:	5 months old		
Substance exposed:	No		
Cause of death:	Sudden Unexpected Death in Infancy		
Reason For Review:	Pending DCP investigation at time of child's death; unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Five-month-old infant was found unresponsive in the morning by a 12-year-old neighbor. His 22-year-old mother was the last one to see him alive the night before when she checked on him at 10:30 p.m. The infant was put to sleep in his crib by his father who reported wrapping the child "like a burrito" and getting "lucky" because he was able to wrap the blanket three times so the infant could not wiggle free. His head was placed on an adult pillow with two small throw pillows on either side, used to prop his bottle for feeding. The child was so tightly swaddled that he suffered bruises to his arms and chest. His death was classified as Sudden Unexpected Death in Infancy, meaning there was no cause of death determined at autopsy, but sleeping arrangements were such that the death could not be called Sudden Infant Death Syndrome. The swaddling of the child was considered a contributing factor in the child's death. The 24-year-old father was indicated for death by neglect to the child. He stated the child likely died because he could not breathe because he was swaddled too tightly or he aspirated on his cereal bottle. These statements confirmed that the father understood the safe feeding and sleeping education he had been provided with by multiple sources, but chose not to follow it.

Prior History: In August 2007, the hotline was called by an anonymous reporter who alleged that the 2-1/2-month-old infant was at substantial risk of physical injury in his parents' care because of the father's cruelty in letting the baby cry, taping a pacifier to the infant's mouth, and hanging the infant upside down. The investigation was unfounded after the investigator observed the infant to be healthy, happy, and free of injuries; the parents denied the allegations and displayed appropriate interaction with the baby; the mother's former foster mother babysat and bathed the infant on several occasions and never witnessed injuries; and the infant's pediatrician had no concerns about the infant's care. The evening before the infant died, at 6:00 p.m., an anonymous reporter, who said she was the babysitter, called the hotline to report that two days earlier she had seen the baby with a rug burn on his arms and legs. Reportedly, the infant got stuck under the couch and his father pulled him out from his feet. The babysitter said she had also seen the father hold the child up in the air by his feet and believed this was dangerous. A report was taken for investigation, but an investigator had not yet met the 24-hour mandate when the child's death was reported the following morning.

Child No. 28	DOB 2/90	DOD 12/07	Undetermined
Age at death:	17 years old		
Substance exposed:	No		
Cause of death:	Carbon monoxide intoxication due to inhalation of smoke and soot due to apartment fire		
Reason For Review:	Child welfare services referral within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Seventeen-year-old girl and her eight-month-old son were killed in an apartment building fire. The mother had full thickness burns to her entire body; the baby had full thickness burns to his face, hands, and chest. Their injuries were so severe that they were declared dead at the scene. The mother, who was a high school student, was staying with her 49-year-old mother, an aunt and her boyfriend, and a sister and her baby in a second floor section 8 apartment of a two-story frame building. The baby's 18-year-old father was at the home and survived the fire. He reported that his girlfriend pushed him out of the window and the last thing he heard was his girlfriend yelling for help. The origin of the fire was thought to be an enclosed area on the second floor that contained the furnace and hot water heater, but the exact point of origin and whether an accelerant was used could not be determined with certainty. The home had passed a Section 8 inspection within the last few months.

Prior History: The family was involved with DCFS in the 1990s because of neglect. The last intact family case was closed in 1997. In October 2004, June 2005, and April 2007, child welfare service referrals were made. Five days after the 17-year-old gave birth to her son, in April 2007, the teenager's mother called the hotline expressing concern for her daughter and grandson. The mother reported that she would not allow her daughter's boyfriend to stay in her home because he had beaten her daughter in December 2006 while she was pregnant with his child. The teenager got mad and left the home with the newborn. The mother reported that the boyfriend was violent to the point that his own family was afraid of his threats of violence. A child welfare services referral was made, and a worker visited the home and provided service referrals.

Child No. 29	DOB 12/07	DOD 2/08	Undetermined
Age at death:	2 months old		
Substance exposed:	Yes, cocaine and opiates		
Cause of death:	Undetermined		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Two-month-old infant was found unresponsive by her 37-year-old father in the morning. The father was co-sleeping with the infant in an adult bed, despite having a bassinet in the home for the infant.

Prior History: The child was the second substance-exposed infant born to her 23-year-old mother. The mother's first child was born substance-exposed in 2003 and was adopted by his foster parent in 2005. When the deceased tested positive for cocaine and opiates at birth, DCFS was contacted and a DCP investigation initiated. The mother was indicated for substance misuse. The child was released to her father, who wished to care for her and obtained necessary baby items, such as a bassinet and car seat. The father was employed, owned an apartment building, and had the assistance of his brother and sister-in-law who lived in his building.

Child No. 30	DOB 1/95	DOD 3/08	Undetermined
Age at death:	13 years old		
Substance exposed:	No		
Cause of death:	Undetermined		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Thirteen-year-old autistic boy was found unresponsive by his 58-year-old father. The boy was experiencing flu-like symptoms and stayed home from school that day. An autopsy revealed no evidence of anatomic disease, infection, or trauma, and a toxicology screen was negative.

Prior History: This family has DCFS involvement dating to 1995. The parents had eight children together. Seven of the children were in foster care for a little over a year during 2002-2003. One remained in DCFS care until his 21st birthday. In October 2005, a preventive services case was opened on the father and children. The parents were divorcing and the father had custody of the children and their mother had visitation every other weekend. The case remained open until December 2006 to help the family remain intact. During this time there was an unfounded DCP investigation involving an accident between 8 and 13-year-old brothers that required the 8-year-old to get stitches. In September 2007, the hotline was called by a hospital nurse who was concerned about the deceased's 11-year-old brother whom the mother had taken to the hospital for a psychiatric evaluation. The boy was reportedly abused by his father, did not want to return to his father's home, and threatened suicide if he was forced to go back. DCP investigated a report of substantial risk of physical injury. The investigation was unfounded after the 11-year-old told the investigator that he did not want to go home to his father because his mother and her boyfriend told him that his father was not his biological father and now he was confused and wondered if he was adopted. He denied any abuse by his father and said he was not afraid of his father. The father reported that his ex-wife had an affair during their marriage. While there were questions about the paternity of a couple of the kids, in his heart he considered them all his children and legally they were his children. The father worked with hospital staff and counselors to help the child deal with his stress and confusion.

Child No. 31	DOB 6/07	DOD 3/08	Undetermined
Age at death:	8 months old		
Substance exposed:	No, however mother has a history of alcohol abuse		
Cause of death:	Undetermined		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Full investigation pending		

Narrative: According to police, thirty-four-year-old mother found her 8-month-old son unresponsive in his crib and called 911. The infant was taken to the hospital where he was pronounced dead. When later interviewed, the parents reported that it was the 41-year-old father who discovered the child. He reported that he found the child lying on his stomach with his face turned to the side with a blanket over him. His breathing was not obstructed. The father was the last person to see the child alive. An autopsy did not reveal a cause of death. Because of the infant's history of injury, the cause and manner of the child's death were undetermined.

Prior History: In August 2007, when the infant was almost two months old, his parents took him to the hospital with his older half-sister because they were sick and had been throwing up. While being examined, a doctor discovered bruising to the child's abdomen. Imaging studies revealed three rib fractures. The mother had asked the father about the bruising and the father denied knowing what caused it. Later, he told the mother that he remembered tripping over a fan cord while carrying the infant in his bouncy seat and falling on top of him. When questioned by police, the father also reported pushing on the infant's stomach to release gas. The doctor evaluating the child's injuries determined that the father's history was inconsistent with the child's injuries, which she believed were inflicted. The father was charged with reckless conduct and ordered by the court to stay out of the home. The father was indicated for cuts, bruises and welts and internal injuries. The mother was unfounded, but an intact family case was opened to engage the mother in services. The mother was not compliant with services, and the father returned to the home. Following the infant's death, the mother was indicated for substantial risk of physical injury to her 10-year-old daughter because she allowed the deceased's father to move back into the home and have unsupervised contact with the children. The daughter entered foster care where she remains.

Child No. 32	**DOB 4/05**	**DOD 3/08**	**Undetermined**
Age at death:	Almost 3 years old		
Substance exposed:	No		
Cause of death:	Undetermined		
Reason For Review:	Open intact family case at time of child's death (father's home)		
Action Taken:	Full investigation, no report issued		

Narrative: Two-and-a-half-year-old child died in her sleep. The child was diagnosed with MCADD (a rare genetic metabolic disorder characterized by a deficiency of the enzyme, medium chain acyl CoA dehydrogenase- MCAD that breaks down fatty acids to provide the body with energy) as an infant. She took medication every day and required regular caloric intake (eating every 4-6 hours). The child was visiting her father for the weekend. While she was there, she vomited, ate little, and had the dry heaves. This behavior necessitated taking the child to a hospital for emergency medical care pursuant to her emergency protocol, however, the child was instead put to bed. The 24-year-old father and his 20-year-old girlfriend were indicated for neglect in the child's death as they had a copy of the emergency protocol and were aware of its contents. They were also indicated for environmental neglect and substantial risk of physical injury to their 17-month-old child. The surviving child is in foster care and is placed with her paternal grandparents. No criminal charges have been filed.

Prior History: In August 2007 the father and his girlfriend were indicated for environmental neglect, and an intact family case was opened. The intact family worker helped the family move to another apartment closer to the father's employment, put a homemaker into place to educate the girlfriend on housekeeping, and monitored the cleanliness of the home. Initially, the worker did not know the father had another child. When he told her, he reported that she only visited occasionally. Because the deceased visited her father on the weekends, neither the worker nor the homemaker had ever met the child.

Child No. 33	**DOB 3/08**	**DOD 4/08**	**Undetermined**
Age at death:	3 weeks old		
Substance exposed:	Yes, cocaine		
Cause of death:	Undetermined		
Reason For Review:	Pending DCP investigation at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Four-month-old child's father awoke an hour after feeding the infant a bottle to discover that the infant appeared to be having trouble breathing. The infant was lying on his back in a play pen next to the bed. The 31-year-old father called 911 and was instructed to perform CPR. Paramedics arrived and transported the infant to the hospital where he was pronounced dead. The father had called 911 four days earlier when the infant had difficulty breathing, but the child was not taken to the hospital at that time. The infant was the 28-year-old mother's second child to die within a year. Please see Child No. 25 above.

Prior History: The deceased was the mother's second substance-exposed infant. The mother gave birth at home and did not take the infant to the hospital until three days later. The infant tested positive for cocaine in the hospital and the hotline was called. The infant was released to the care of his father, who DCFS assessed as willing and able to care for the infant. A drug and alcohol assessment and a home safety assessment were completed. The father had clothes, a car seat, baby swing, and a playpen for the infant. The dangers of co-sleeping were discussed with the father, and he was given a referral to WIC. The father was informed that the mother was to have only supervised contact with the infant, and she was not to stay in the home overnight. At the time of the infant's death, the mother was staying elsewhere. The mother was indicated for substance misuse following the child's death.

Child No. 34	**DOB 3/08**	**DOD 4/08**	**Undetermined**
Age at death:	5 weeks old		
Substance exposed:	No		
Cause of death:	Sudden Unexplained Death in Infancy		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Five-week-old infant was found unresponsive by her 24-year-old father. 911 was called, and the infant was taken to the hospital where she was pronounced dead. According to the parents, the family had gone to bed at approximately 12:30 a.m. after the father returned home from work. The family slept on two mattresses, one twin and one full, placed next to each other on the bedroom floor. The father slept with the infant on the twin and the 25-year-old mother slept on the full with their 1, 3, and 4-year-old children. Normally, the mother slept with the infant, but on that evening, she slept with the other children because one of them had a fever. The father was described as a very sound sleeper. When the father awoke, he noticed the infant was covered by a comforter and not breathing. Police, responding to the call, found the house trailer in filthy condition and called the hotline. The parents were indicated for environmental neglect, and an intact family case was opened. In August 2008, the parents were indicated for substantial risk of physical injury after they attempted to elude police and drove intoxicated with their children in the car without their headlights on. The children entered foster care and were placed with their maternal grandparents where they remain.

Prior History: In February 2006 the father was indicated for substantial risk of physical injury after he drove intoxicated with his two children in the car. In October 2007, the parents were indicated for environmental neglect because of the unsanitary and unsafe conditions found in the family's apartment. The family was offered services, but they refused them.

Child No. 35	**DOB 4/08**	**DOD 6/08**	**Undetermined**
Age at death:	2 months old		
Substance exposed:	No		
Cause of death:	Undetermined		
Reason For Review:	Pending DCP investigation		
Action Taken:	Investigatory review of records		

Narrative: Two-month-old infant, who was sleeping in an adult bed with her mother, was found unresponsive at 6:00 a.m. The 23-year-old mother and her three children, ages 1, 2, and 2 months, were staying in a shelter. The infant was last seen alive at 2:00 a.m. by a staff member who checked on her. Around 10:30 p.m. the night before, the infant had fallen out of the bed she shared with her mother onto a concrete floor. Shelter staff called 911, and the family went to the hospital. The mother returned to the shelter before the infant was seen by a doctor because there was a long wait. The mother had a bassinette in her room at the shelter, but did not use it. An autopsy was completed on the infant, but no cause of death could be determined. The mother was indicated for death by neglect and substantial risk of physical injury to her surviving children. An intact family case was opened.

Prior History: In April 2008, a week after the deceased's birth, the hotline was called with a report of substantial risk of physical injury to the 2-year-old child by his 31-year-old father. The family was staying in a shelter, and a staff member witnessed the father slap the 2-year-old child on the side of the head with an open hand and threaten to whip the child. The child was not injured. The mother moved to another shelter (the one where the infant died) without the father and reported they were no longer together.

ACCIDENT

Child No. 36 & 37	DOB 4/00 8/93	DOD 8/07 8/07	Accident
Age at death:	7 and 14 years old		
Substance exposed:	No		
Cause of death:	Drowning		
Reason For Review:	Open intact family case		
Action Taken:	Investigatory review of records		
Narrative: Seven and 14-year-old siblings were on an outing with family members and friends. The siblings went swimming with a group of children in Lake Michigan. Some of the children were pulled under by a current. They were rescued by fire department personnel, but the 7- and 14-year-old siblings did not survive. There were no lifeguards and no "no swimming" signs posted at the site, which was known by people who worked in the area as a popular, but dangerous place to swim because of the strong undertow.			
Prior History: In February 2007 the 33-year-old single mother of eight was indicated for environmental neglect to her 8-year-old twins, who were reported to regularly attend school with dirty clothes and foul odor. The investigation was the second for this issue, and the mother had previously been counseled about the importance of good hygiene. An intact family case was opened. Prior to the children's death, the intact family services worker was addressing hygiene and cleanliness issues. She also helped the family find new housing and catch up on their utility bills. The intact family case remained open for a year following the children's deaths.			

Child No. 38	DOB 7/98	DOD 8/07	Accident
Age at death:	9 years old		
Substance exposed:	Unknown		
Cause of death:	Aspiration of a foreign object		
Reason For Review:	Unfounded DCP investigations within a year of child's death		
Action Taken:	Full investigation; report to Director 2/21/08		
Narrative: Nine-year-old adopted child choked on a ring cap, a plastic toy that was part of an "Auto Fire Target Set" consisting of a small target, a toy gun, and eight ring caps. The child's death and toy set were reported to the Consumer Product Safety Commission.			
Prior History: In May and July 2007, there were two appropriately unfounded child protection investigations involving the adoptive family. The 60 and 62-year-old adoptive parents had been foster parents since 2003. In 2006, they adopted three siblings who had been in their foster care for almost three years. The deceased was one of them. All three children had mental health diagnoses. During the child protection investigations, the home was not flagged as a foster home facility. Even though a DCFS ward was living in the home at the time of the second investigation, he was not identified as a member of the household, let alone as a foster child. Contrary to Procedures, neither the Department's Agency and Institution Licensing Unit nor the private agency's licensing unit was notified about a pending DCP investigation involving the foster home. See Death and Serious Injury Investigation #8.			

Child No. 39	DOB 6/07	DOD 8/07	Accident
Age at death:	Just shy of 2 months old		
Substance exposed:	No, however, the mother has a history of substance abuse		
Cause of death:	Overlay		
Reason For Review:	Pending DCP investigation at time of child's death; unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation pending		

Narrative: Eighteen-year-old aunt discovered her eight-week-old nephew laying under her 12-year-old nephew, the infant's cousin. The infant was unresponsive. The aunt handed him to her 29-year-old sister who immediately ran with the infant to an emergency center located a block away from their home. The infant was rushed to the local hospital where he was pronounced dead. The infant and his siblings were staying overnight at the 29-year-old aunt's home.

Prior History: The deceased was his 33-year-old mother's seventh child. In June 2007, the mother called the hotline alleging that her maternal grandmother was not adequately feeding the children in her home, including the mother's five oldest children who were in the guardianship of their maternal great-grandmother. A report was taken for investigation of inadequate food. It appeared the grandmother was having problems, but was adequately feeding the kids. During the investigation, the maternal grandmother had a stroke and went to live with one of her daughters. The mother and her children were left homeless, and the mother reported that they were going to go to a shelter in a neighbor state. The investigation was unfounded. In August 2007, two days prior to the infant's death, an adult cousin called the hotline stating that the mother left her two daughters, ages 6 and 11, with the cousin six or seven days ago and had not returned for them. The relative reported that the mother was homeless and addicted to drugs. The mother was indicated for inadequate supervision. She entered a long-term women's shelter with her two daughters and left her four older sons in the care of relatives. No follow-up case was opened.

Child No. 40, 41 & 42	**DOB 1/92; 12/96; 9/88**	**DOD 8/07**	**Accident**
Age at death:	10, 15, and 18 years old		
Substance exposed:	No		
Cause of death:	Multiple blunt force trauma due to auto accident		
Reason For Review:	Children were wards; teenager was a ward within a year of her death		
Action Taken:	Investigatory review of records		

Narrative: Ten and 15-year-old wards and their 18-year-old sister, who was a ward until five months earlier, were victims of a head on automobile collision. The girls' 42-year-old mother and 5-month-old nephew survived the crash. The mother, who was driving without a license, lost control of her car and struck another vehicle head on. None of the occupants of the car were wearing seat belts, and the infant was not restrained in a car seat. All five passengers were ejected from the car. The family had been traveling to visit the 5-month-old infant's father in prison.

Prior History: The family has history with DCFS dating to 2002 when the oldest girl was struck by her father and sustained a black eye. The children were in foster care for six months in 2002. They reentered foster care in 2005. In 2007 the oldest girl was released from guardianship because she had turned 18, and the goal for the two younger girls was changed from return home to guardianship with their foster parent because the mother was noncompliant with services. In July 2007, both girls went on run from their foster home. The caseworker made weekly attempts to locate the girls. She also filed missing person reports with the police, obtained juvenile arrest warrants, and registered the girls with the National Center for Missing and Exploited Children. Shortly before the accident, the girls had contacted their foster mother to tell her they would be home in time to start school.

Child No. 43	**DOB 10/07**	**DOD 10/07**	**Accident**
Age at death:	25 days old		
Substance exposed:	No		
Cause of death:	Asphyxia due to soft bedding		
Reason For Review:	Child welfare services referral at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twenty-five-day-old infant was found unresponsive by a cousin in the morning. He and his mother had been visiting his aunt, and they spent the night. He had been placed to sleep on a twin-size bed.

Prior History: The family's first involvement was in December 2004 when the mother was indicated on a report of environmental neglect because her home was dirty and filled with roaches. Services were offered to the mother, but she refused them. In October 2007, the 28-year-old mother of seven called the hotline to request assistance with housing, reporting that she had just moved back to the area from a neighboring state. A child welfare services referral was made, and a worker called the mother two days later. The worker made two referrals over the phone and asked the mother to call her in a week with her employment status (the mother was waiting to hear about a job), so that she could be referred for Norman (housing) funds. The infant died two days later. In March 2008, an extended family support services case was opened to help the grandmother with three of the children for whom she had assumed care. The case was closed in June 2008.

Child No. 44	**DOB 7/03**	**DOD 11/07**	**Accident**
Age at death:	Four years old		
Substance exposed:	No		
Cause of death:	Carbon monoxide intoxication due to inhalation of smoke and soot due to a house fire		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Full investigation pending		

Narrative: Four-year-old child died in a house fire at his maternal grandmother's home. He was in the home with his mother and grandmother when they smelled smoke and went outside. Once outside, the child ran back into the house and the door locked behind him. His mother tried to break a window and get inside, but there was too much smoke, and the fire department arrived and pulled her out. The firemen found the child in his bed, but they couldn't save him. Fire investigators found that the fire originated in the basement of the home and was most likely caused by an electrical fan that was found melted into a mattress. The child's 13-year-old brother was not home at the time of the fire.

Prior History: This family has a history with DCFS dating to October 2005 because of the parents' alcohol abuse and domestic violence. They have had three indicated reports of substantial risk of physical injury and two intact family cases. The second intact family case was open at the time of the child's death. The 38-year-old mother had separated from the 46-year-old father, and she and her children were staying with the maternal grandmother. The mother and her surviving child continued to participate in intact family services after the child's death. Their case was closed in July 2008.

Child No. 45	**DOB 9/07**	**DOD 12/07**	**Accident**
Age at death:	2 months old		
Substance exposed:	Yes, alcohol		
Cause of death:	Overlay		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Nineteen-year-old mother woke up at 7:00 a.m. and attempted to feed her medically complex 2-month-old infant. He would not eat, so she laid him in bed with her. She fell asleep. She woke up an hour later and found him unresponsive. The coroner's office reported smelling alcohol on the mother, but alcohol use was never confirmed. The coroner's physician called the infant's death the result of overlay, despite the mother's report that she did not lay on the infant.

Prior History: There was an intact family case open on the 30-year-old father and his three children from a prior marriage from September 2005 until September 2007, shortly before the infant's birth. The case was closed because the children went to live with their grandmother. Substance abuse services had been offered to the father and the mother of the deceased, but they did not participate. The deceased was born with fetal alcohol syndrome and other medical complications that required him to stay in the neonatal intensive care unit for his first couple weeks of life. The mother admitted to drinking up to a fifth of vodka per day. She tried to stop when she found out she was pregnant, but it was difficult. The mother was indicated for substance misuse, an intact family case was opened, and the mother was put under court supervision. The infant was receiving home health care visits, the mother had completed a substance abuse assessment, the mother was engaged in outpatient treatment services, and she was undergoing breathalyzer tests. There was a bassinette in the home.

Child No. 46	**DOB 4/90**	**DOD 12/07**	**Accident**
Age at death:	17 years old		
Substance exposed:	Unknown		
Cause of death:	Tramadol overdose		
Reason For Review:	Teenager was a ward		
Action Taken:	Investigatory review of records		

Narrative: Foster mother went to wake up 17-year-old ward for school and found him unresponsive. She had last seen him alive around 9 p.m. the night before when he went to bed. The ward had been diagnosed with cardio myopathy. At autopsy he was diagnosed with Marfan Syndrome (an inherited condition that affects the connective tissue) for which cardio myopathy is a symptom. The teenager was thought to have died from these conditions, but toxicology results revealed the ward had overdosed on Tramadol, a prescription pain reliever. Neither the ward nor any member of his foster family was prescribed the drug. The coroner theorized that the ward was trading his Risperidal for Tramadol because he had no Risperidal in his system. There was no police investigation of the child's death.

Prior History: The ward entered foster care as an infant and was adopted when he was 2-1/2 years old. The adoptive parents separated when the ward was in his early teens. First, the boy lived with his mother and her boyfriend, but went to live with his father after reporting that his mother's boyfriend abused him. The mother wanted no further involvement with the boy. The father tried his best to care for the teen who was developmentally delayed and easily influenced by his peers. After the teen began engaging in criminal behavior and smoking marijuana daily, the father could no longer handle him, and he reentered foster care in February 2006. The teen lived in only one foster home where he was doing fairly well. He attended school, engaged in counseling, and visited with his father on occasion.

Child No. 47	**DOB 1/07**	**DOD 12/07**	**Accident**
Age at death:	11 months old		
Substance exposed:	No		
Cause of death:	Burns and smoke inhalation		
Reason For Review:	Child was a ward		
Action Taken:	Full investigation; report to Director 6/25/08		

Narrative: Eleven-month-old ward died within hours of being a victim of a house fire. She suffered from smoke inhalation and burns over 33% of her body. The fire occurred in her foster home. She was the only fatality among the seven occupants of the home. Fire investigators were unable to determine the cause of the fire, but the house had four working smoke detectors.

Prior History: This family first came to the attention of DCFS in 2002 when the 17-year-old mother took her second child to the doctor with a broken arm. The mother explained that the baby swing crashed to the ground while the baby was in it. The investigator observed the swing and found the explanation plausible, but he also found the living conditions of the home to be deplorable. The mother was indicated for environmental neglect and an intact family case was opened. In August 2003, the mother's three children entered foster care after cuts, bruises, and welts were discovered on the two older children without explanation. The mother's parental rights were terminated on the three children, and they were adopted by their foster parents in November 2006. Two months later, the deceased was born, and entered foster care because her mother had been found unfit to parent. In June 2007, the deceased was placed in the home of her siblings, where the fire later occurred. See Death and Serious Injury Investigation #15.

Child No. 48	DOB 8/07	DOD 1/08	Accident
Age at death:	4 months old		
Substance exposed:	No		
Cause of death:	Sudden Unexplained Death in Infancy		
Reason For Review:	Open return home case at time of child's death and unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Four-month-old infant stayed overnight with his siblings at his maternal grandmother's home. His 19-year-old mother was moving into a new apartment for herself, the infant, and his two older siblings. The maternal grandmother's 11-year-old daughter, 15-year-old son, and the infant slept together in the same bed. When the daughter woke up, she found the infant unresponsive. According to the autopsy, there was no evidence of trauma or abuse to the infant, but "it is possible for an infant to asphyxiate within an adult sleeping environment with adult blankets and bed sharing without leaving a mark or any evidence of its occurrence at autopsy."

Prior History: In March 2004, the State's Attorney's Office filed a petition alleging that the 16-year-old mother's 1-year-old son was living in an environment injurious to his welfare because of his mother's juvenile delinquency. In March 2005, the child entered DCFS care because his mother violated a court order that she and her son have no contact with her boyfriend who was a child sexual offender and gang member. The child was placed with his maternal grandmother. The mother participated in services, and in August 2007, the 4-year-old child returned to his mother's care under a court order. In October 2007, a nurse called the hotline alleging medical neglect to the mother's 16-month-old son, who missed an August medical appointment with a urologist. The child needed surgery because he was born with bilateral undescended testicles. The mother had not responded to phone calls and letters requesting that she reschedule the appointment. The investigation was unfounded because the mother claimed she was not aware of the appointment, the child's primary care physician did not feel the failure to keep the appointment rose to the level of medical neglect, and within a week of the hotline report, the mother scheduled and kept the appointment. In January 2008, two weeks after her youngest child's death, the oldest child's court case was closed.

Child No. 49	DOB 11/07	DOD 2/08	Accident
Age at death:	2-1/2 months old		
Substance exposed:	No		
Cause of death:	Suffocation due to face down in soft bedding		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Two-and-a-half-month-old infant was found unresponsive by her 17-year-old mother. The infant had been placed to sleep in a bassinette on her side. When she was found, the infant's face was laying against the side of the bassinette in a blanket. The infant appeared to be healthy and well-cared for prior to her death, with her nutrition, hydration, and cleanliness noted to be good at autopsy.

Prior History: After she gave birth, the mother claimed to have found the newborn crying in the woods and enlisted the help of a friend whose mother was a nurse. The infant was taken to the hospital, and the police were called. A report was taken by DCFS for investigation of abandonment. The investigation was unfounded. The mother admitted to police that the baby was hers and that she had given birth at home. Only her boyfriend knew that she was pregnant. Initially, the mother wanted to give the baby up for adoption, but changed her mind and wanted to keep her child. She had the support and help of her father and brother with whom she lived. She also had the support of two adult cousins and an aunt. There was a bassinette in the home.

Child No. 50	**DOB 11/95**	**DOD 4/08**	**Accident**
Age at death:	12 years old		
Substance exposed:	No		
Cause of death:	Severe head and torso trauma		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twelve-year-old boy was skateboarding without a helmet or any other protective gear. His 38-year-old father allowed him to hold onto the back of the car driven by the father with his 14-year-old brother in the passenger seat. The child fell and was run over by the car. The father lied to police about his involvement in his son's death, but witnesses including the brother reported that the child was being pulled by his father. The father was charged with child endangerment and reckless homicide. He was indicated for death by neglect and substantial risk of physical injury.

Prior History: In August 2007, law enforcement called the hotline with allegations of substantial risk of physical injury by the mother to the older of her two sons. The parents were divorced and the child had been visiting his father. The child and his father went to the police station stating the child did not want to return to his mother's home because of abuse. The police reported that they had been dealing with custody/visitation issues with this family for the past couple of years. The DCP investigator interviewed all parties. The older boy sided with his father and the younger boy sided with his mother. Both boys ended up at their mother's home. The investigator checked on the children at the end of the investigation and the children reported feeling safe in their mother's care. At that time, the older brother said he did not want to return to his father's home. The investigation was unfounded.

Child No. 51	**DOB 11/07**	**DOD 5/08**	**Accident**
Age at death:	6 months old		
Substance exposed:	No		
Cause of death:	Asphyxia due to wedging		
Reason For Review:	Indicated DCP investigation within a year of child's death; child of a ward		
Action Taken:	Full investigation pending		

Narrative: Eighteen-year-old DCFS ward found her six-month-old daughter pinned between the wall and the mattress of the adult bed they were sharing. The mother had been up all night playing games on the computer. She went to bed at 9:30 a.m. and slept for about 2-1/2 hours until the woman she was staying with brought the baby to her. She fed the baby and laid her face down on the mattress which she had arranged next to the wall. The mother then fell asleep. Around 3:30 p.m., the mother awoke and found the baby unresponsive.

Prior History: The developmentally delayed mother has been a ward since July 1992 because of neglect. She has lived in foster homes and group homes and frequently was on run from her placements. From August 2003 to the time of her baby's death, the mother rarely remained in place for more than a month at a time. The day after the baby's birth, the hotline was called with a report of substantial risk of physical injury to the baby because of the mother's history of instability, aggressiveness, impulsivity, and her plan to take the infant to an unsafe home. The investigation was indicated in February 2008. The investigator attempted to screen the infant into court, but was unsuccessful. The mother's worker continued to search for a placement where the mother was willing to stay, but the infant's six months of life were marked by instability.

Child No. 52	**DOB 10/05**	**DOD 5/08**	**Accident**
Age at death:	2-1/2 years old		
Substance exposed:	No		
Cause of death:	Multiple injuries due to automobile striking pedestrian		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Thirteen-year-old child was watching her 2-1/2-year-old brother on the steps in front of the house while her mother ran inside. They were getting ready to go to the store. The little boy saw his cousin across the street and ran down the stairs, turning and laughing at his sister. He turned again when he got to the curb and then ran into the street and was hit by a car. The driver stopped. A witness reported the car did not appear to be speeding. The driver was cited for striking a pedestrian and driving with a suspended license. A child protection investigation against the mother for neglect in the child's death was unfounded. The deceased was the youngest of four siblings.

Prior History: In March 2008, a relative called the hotline complaining that the mother had dropped the deceased off with another relative two days earlier and never returned. The relative calling the hotline took the child home with her, and the mother showed up and took the child. The reporter stated that the mother had also left her other children with various relatives. The report was unfounded after investigation. The child protection investigator could not locate the mother or children. The relative who called the hotline had a wrong address for the mother; the mother was not currently receiving public aid, and she was not living at her inactive case address; and a search by the Diligent Search Service Center did not find a possible address. At the time of the child's death, the mother and her four children were living with her mother and step-father.

Child No. 53	**DOB 3/08**	**DOD 5/08**	**Accident**
Age at death:	2 months old		
Substance exposed:	No		
Cause of death:	Asphyxia due to lying face down on an adult water bed		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Two-month-old infant was laid down for a nap on her back on her 50-year-old day care provider's adult water bed. When the day care provider checked on the infant, she had rolled over and was lying face down with her arms above her head. The day care provider had been providing licensed day care without complaint since 2000. The water bed was in the master bedroom of the home which was excluded from use for day care. The provider reported that on this particular day, she moved the baby to the bedroom to sleep because her brother kept poking at her trying to wake her. The provider was indicated for death by neglect. She voluntarily surrendered her day care license.

Prior History: The infant entered foster care for substantial risk of physical injury following her birth. She was placed with her two older siblings in the care of their paternal grandmother. Her siblings, 1-1/2 and 3-1/2, had entered foster care in February 2007 for substantial risk of physical injury because of the 22-year-old mother and 20-year-old father's substance abuse. At the time of the deceased's birth, the mother had been compliant with services for four months, but she had made little progress in the prior year. The two surviving siblings have goals of return home.

Child No. 54	DOB 5/08	DOD 5/08	Accident
Age at death:	20 days old		
Substance exposed:	No		
Cause of death:	Positional asphyxia		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twenty-day-old infant was found unresponsive by a friend of the mother's around 10:00 a.m. The infant reportedly had a cold. His 22-year-old mother placed him to sleep face down on a pillow. The mother was indicated for death by neglect because she had previously been educated about unsafe sleeping practices, including the use of soft bedding, and she had not checked on the 3-week-old infant for ten hours. During the investigation, other incidents of neglect and possible abuse to the surviving siblings, ages 2 and 3, came to light. The children were placed in their father's custody with supervised visitation for their mother. The paternal grandparents, with whom the father and children lived, were helping to care for the children.

Prior History: In May 2007, an anonymous reporter called the hotline stating that the parents' domestic violence was placing their 3-year-old and 11-month-old children at substantial risk of physical injury. The mother was unfounded on the report. The 25-year-old father was indicated on the report as he was arrested for domestic battery. He attacked the mother while the children were present, and the mother called the police. Police took four weapons out of the home. The father agreed to reside with his parents and to attend anger management counseling; the mother was referred to domestic violence counseling; and the couple was attending counseling with their pastor, who spoke with the investigator. The investigator cautioned the parents that another reported incident of domestic violence would result in a referral to the State's Attorney's Office for consideration of removing the children from their parents. In May 2008, the mother gave birth to the deceased, the couple's third child, but they were not living with each other at the time of the infant's death.

Child No. 55	DOB 9/04	DOD 5/08	Accident
Age at death:	3-1/2 years old		
Substance exposed:	No		
Cause of death:	Massive head trauma due to pedestrian struck by train		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Three-and-a-half-year-old girl played in the backyard of her grandmother's home with her 7-year-old sister and an eight-year-old friend. A 15-year-old cousin, who was supervising the girls, went into the house to make lunch. The three girls left the fenced-in backyard through a gate and crossed the train tracks approximately two houses down to throw rocks in the pond on the other side. The girls heard a train coming and wanted to go home because they knew they weren't supposed to be there. The 7 and 8-year-old girls crossed the tracks safely, but the 3-year-old hesitated, then crossed and was struck by a freight train. The grandmother had returned home shortly before the incident, but had not checked on the children. She was indicated for inadequate supervision of the children. The family was referred to services in the community.

Prior History: In July 2007, the hotline was called with a report of substantial risk of physical injury to the 7-year-old by her step-father because of abusive behavior. The family denied that the step-father was abusive. The mother and step-father both worked two jobs so the girls stayed with their maternal grandmother six days a week. The grandmother reported that her son-in-law did not hit her daughter or grandchildren. She also said the family could move in with her at any time. The investigation was unfounded.

Child No. 56	DOB 8/93	DOD 6/08	Accident
Age at death:	14 years old		
Substance exposed:	No		
Cause of death:	Drowning		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Fourteen-year-old boy and his friends jumped the fence of a closed apartment complex swimming pool to go swimming. The boy jumped in the water and started flailing; his friends thought he was playing around. When they realized he was drowning, they pulled him out of the pool and performed CPR while a passerby called 911. The child was pronounced dead that evening at the hospital where he was taken. His mother reported he did not know how to swim.

Prior History: In February 2008, the Department investigated a report of risk of harm to the deceased by his mother's boyfriend. The teenager and the boyfriend got into a verbal altercation while the mother was at work because the teen would not stop picking on his 10-year-old brother. The altercation escalated to the point that each grabbed a weapon, and the 10-year-old called 911. Neither party used the weapons (a knife and a broom), and the police did not arrest anyone. The boyfriend voluntarily left the home, the mother reported that he would not be back in the home, and the 10-year-old confirmed that he had not been back since the incident. The investigation was unfounded.

Child No. 57	DOB 5/08	DOD 6/08	Accident
Age at death:	3 weeks old		
Substance exposed:	No		
Cause of death:	Asphyxia due to overlay		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Full investigation pending		

Narrative: Twenty-seven-year-old mother found her three-week-old infant unresponsive. The mother got home at approximately 1:00 a.m. The infant was asleep with his maternal grandmother. The mother picked him up and laid him on a mattress in another room with herself and her two and four-year-old children. There was no crib in the home. Police, responding to the 911 call, found the home in deplorable condition and a report of environmental neglect and substantial risk of physical injury was taken for investigation. The mother was indicated on the report, and an intact family case was opened.

Prior History: In March 2008, three months prior to the infant's death, the hotline was called with a report of medical neglect to the mother's eleven-year-old daughter. The child had been taken to the emergency room after suffering several seizures. The child had a history of seizure disorder for which the mother was not administering medication or seeking medical treatment. The mother was indicated for medical neglect and substantial risk of physical injury and was referred to a community based agency for follow-up. The mother was pregnant with the deceased at the time of the investigation; the investigator advised the mother to get a crib for the infant because bed-sharing was unsafe.

Child No. 58	DOB 11/04	DOD 6/08	Accident
Age at death:	3-1/2 years old		
Substance exposed:	No		
Cause of death:	Craniocerebral injuries due to being crushed under a metal gate		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Three-and-a-half-year-old child died from head injuries he sustained when he was crushed under a metal gate. Children were playing on the gate while the 3-1/2-year-old was riding his tricycle. The gate became dislodged from its hinges and struck the boy.

Prior History: There were two prior DCP investigations involving this family. The first occurred in October 2006 when the 21-year-old mother flagged down a police car stating that she dropped her 2-1/2-month-old son during an incident of domestic violence with her son's father. The infant had no injuries. The 27-year-old father was indicated for substantial risk of physical injury to the infant. The mother obtained an emergency order of protection against the father and planned to move with her two children to another city to live with an aunt. In October 2007, the deceased was taken to the hospital by his mother with a complaint of an injured penis. The mother reported that she grabbed the child's penis in an attempt for him to urinate and had not realized that she grabbed him too hard. The injury was consistent with her explanation. A referral was made for the mother to attend parenting classes, which she agreed to do, and the investigation was unfounded for cuts, bruises and welts.

NATURAL

Child No. 59	DOB 8/92	DOD 7/07	Natural
Age at death:	Almost 15 years old		
Substance exposed:	No		
Cause of death:	Cerebral Palsy		
Reason For Review:	Open intact family case within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Thirty-three-year-old mother found her medically complex 15-year-old son unresponsive. She had last seen him alive when she filled his feeding tube 3-1/2 hours earlier. The child was seen by his doctor two weeks prior and had been doing okay. The deceased was an only child.

Prior History: In May 2006 the Department investigated a report of neglect to the deceased by his mother. The mother was unfounded on allegations of medical neglect, inadequate supervision, and environmental neglect. During the investigation, the child was seen by his pediatrician who reported that he appeared okay and had gained 2 pounds in the last six months. While doctors would not say the child was medically neglected, the mother had missed several appointments with specialists the child was supposed to be seeing. The mother was indicated for substantial risk of physical injury, and an intact family case was opened. The case remained open for 3-1/2 months during which time a DCFS nurse visited the child, the caseworker monitored his medical appointments, and the mother completed parenting classes.

Child No. 60	DOB 10/06	DOD 7/07	Natural
Age at death:	9 months old		
Substance exposed:	No		
Cause of death:	Bronchopulmonary dysplasia due to prematurity		
Reason For Review:	Split custody case (sibling was in foster care)		
Action Taken:	Investigatory review of records		

Narrative: Nine-month-old medically complex infant was found unresponsive by her mother and a home health nurse. They called 911and the infant was taken to the hospital where she was pronounced dead. The infant was born 10 weeks prematurely and was infected with ecoli pneumonia while in the hospital. She was hospitalized for the first 7-1/2 months of her life. She was released from the hospital with home health care in place.

Prior History: The family first came to the attention of DCFS in November 2003 when the 17-year-old mother and 20-year-old father were indicated for abuse to their 2-1/2-month-old son. The child entered foster care and was placed with his maternal grandmother. The parents worked toward the child's return home by participating in services including counseling and substance abuse treatment. Shortly before their daughter's birth, the parents had gained unsupervised overnight visitation with their son. After the baby's birth, the parents' participation in services waned, but their care of the infant, when she was released from the hospital, was noted to be good. Following his baby sister's death, the sibling's permanency goal was changed in November 2007 from return home to subsidized guardianship with his grandmother.

Child No. 61	DOB 10/95	DOD 7/07	Natural
Age at death:	11 years old		
Substance exposed:	No		
Cause of death:	Sepsis with cerebral palsy a significant contributing factor		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Eleven-year-old medically complex ward was found unresponsive by staff at her specialized care group home and was taken to the hospital where she was pronounced dead. The ward was very ill with multiple organ system failure and Leigh's Syndrome (a rare neurometabolic disorder that affects the central nervous system). She had been released from the hospital three weeks earlier after a three month admission. She has three surviving siblings who are not DCFS-involved.

Prior History: The deceased first came to DCFS's attention when she was nine months old and doctors were trying to determine what was wrong with her. An intact family case was opened at that time and remained open until March 1999. Twice during that time her mother was indicated for medical neglect. When the child was hospitalized in December 2005 for fever and dehydration, doctors noticed a significant weight loss, and the child was diagnosed with non-organic failure to thrive. Medical staff wanted the mother to authorize placement of the child in a nursing home, but the mother refused, wanting to care for her at home. Ultimately, doctors decided the child could not be adequately cared for at home, and she entered DCFS custody in January 2006. She was placed in her group home in March 2006 when she was released from the hospital.

Child No. 62	**DOB 7/07**	**DOD 7/07**	**Natural**
Age at death:	0		
Substance exposed:	Yes, mother tested positive for cocaine at time of birth		
Cause of death:	Intrauterine Fetal Demise		
Reason For Review:	Open placement case (siblings in foster care)		
Action Taken:	Preliminary investigation		

Narrative: Infant was stillborn at approximately 26 weeks gestation. The 23-year-old mother used cocaine throughout her pregnancy and tested positive for cocaine at the time of the infant's stillbirth.

Prior History: The deceased was the mother's fourth child. Her oldest child was reportedly adopted by the paternal grandmother and lives in California. The mother's other two children entered foster care in Illinois in February 2006 after the younger child was born substance-exposed. The mother failed to participate in services and her parental rights were terminated on the two children in September and December 2007. One child was adopted in May 2008; the other child's adoption should be completed in early 2009.

Child No. 63	**DOB 4/88**	**DOD 8/07**	**Natural**
Age at death:	19 years old		
Substance exposed:	Unknown		
Cause of death:	Sepsis due to bronchopneumonia with Duchenne Muscular Dystrophy a significant contributing condition		
Reason For Review:	Teenager was a ward		
Action Taken:	Investigatory review of records		

Narrative: Nineteen-year-old ward with muscular dystrophy went for a walk outside in his motorized wheelchair. A passerby called 911 after he discovered the ward slumped over in his wheelchair. The ward was taken to the hospital where he died the following day. At the time he went for his walk, the ward was being supervised by a private in-home nurse, who opted not to go for the walk.

Prior History: The ward and his three siblings entered foster care in 1998 after three years of intact family services because of his mother's neglect. The ward had Duchenne Muscular Dystrophy (DMD), the most severe form of muscular dystrophy in which the muscles break down because of a lack of the protein, dystrophin. The life span for a child with DMD is about 20 years. At the time of his death, the ward was in a foster home for children with special needs. He had been there almost two years and was happy. Previously, he had lived in a residential care facility.

Child No. 64	DOB 7/07	DOD 8/07	Natural
Age at death:	Almost one month old		
Substance exposed:	No		
Cause of death:	Congenital heart abnormality due to trisomy 18		
Reason For Review:	Open placement case (sibling in foster care); pending DCP investigation at time of infant's death		
Action Taken:	Investigatory review of records		

Narrative: Three-week-old infant died in the hospital where he had been cared for since birth. He was born with the genetic disorder trisomy 18. Half of all infants born with the disorder do not survive beyond one week of life.

Prior History: The infant's 37-year-old mother has a history with DCFS dating to 2001 because of substance abuse. The deceased was the mother's sixth child. Her fourth child was born at home in 2003 while the mother was in a drug-induced state. The mother was indicated for substance misuse and substantial risk of physical injury, and her children entered foster care. Her fifth child was also born substance-exposed in 2005 and placed in foster care. Four of the children were adopted in 2005 and 2006. The fifth child was still in foster care at time of the infant's birth and death. He has a goal of return home. In January 2007, the mother attended a 28-day inpatient substance abuse treatment program and then continued to attend outpatient treatment. She had had only one relapse in February 2007. She was looking forward to the birth of the baby and felt she had made progress in turning her life around.

Child No. 65	DOB 8/07	DOD 8/07	Natural
Age at death:	0		
Substance exposed:	Yes, mother tested positive for cocaine		
Cause of death:	Stillborn		
Reason For Review:	Open placement case (siblings in foster care)		
Action Taken:	Investigatory review of records		

Narrative: Twenty-six-year-old mother delivered a stillborn infant at 33 weeks gestation. The mother's DCFS caseworker did not know the mother was pregnant until two weeks earlier when she asked the mother if she was pregnant and the mother admitted to it.

Prior History: The family's first involvement with DCFS was in May 2005 when the mother was indicated for substantial risk of physical injury to her 8-year-old son for using him to help her steal baby formula which she then resold. The mother was referred to community based services. Seven months later, she gave birth to her second child. The infant was born substance-exposed, and an intact family case was opened. A month later, both children entered foster care because the mother would not participate in substance abuse treatment or follow through on recommendations regarding her newborn who was still hospitalized. After two failed relative placements, the children were placed together in a traditional foster home. Shortly after the child's death, the children's permanency goal was changed from return home to guardianship because of the mother's sporadic participation in services.

Child No. 66	DOB 3/07	DOD 8/07	Natural
Age at death:	Almost 5 months old		
Substance exposed:	No		
Cause of death:	Dehydration		
Reason For Review:	Indicated and unfounded DCP investigations within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: The police and fire departments responded to a 911 call from a family member who had found the 5-month-old infant unresponsive. He was last seen alive by his 21-year-old father several hours earlier. The 20-year-old mother reported that the infant had not been sick recently, except for a runny nose. *Note: infants can dehydrate quickly and not appear ill.*

Prior History: In May 2006, the mother's 20-month-old daughter was taken to the hospital with rectal bleeding. She had an anal tear thought to be caused by insertion of an object into her rectum. A perpetrator could not be identified by police, and DCFS indicated "an unknown perpetrator" for sexual abuse. In November 2006 a relative called the hotline reporting that someone investigated by the police for the sexual abuse was living with the mother and child. The investigation was unfounded when it was determined that he was not living with the family.

Child No. 67	**DOB 8/07**	**DOD 8/07**	**Natural**
Age at death:	0		
Substance exposed:	Yes; mother tested positive for cocaine, opiates, and alcohol		
Cause of death:	Prematurity		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Full investigation; report to Director 5/16/08		

Narrative: Infant, who was born at 25 weeks gestation, lived only for a few minutes. The 23-year-old mother tested positive for cocaine, opiates, and alcohol at the time of the infant's birth.

Prior History: Two months prior to the infant's birth, the maternal grandmother called the hotline reporting that she took her 9-month-old grandson home that morning to find her daughter's door wide open and her daughter lying on the bed naked and high as a kite. The house was trashed. She took her grandson back home with her. The hotline took a report for investigation of substantial risk of physical injury and environmental neglect. The grandmother agreed to keep her grandson while her daughter pursued substance abuse treatment. The investigator referred the mother to a treatment provider and indicated the investigation, but no follow-up case was opened. See Death and Serious Injury Investigation #14

Child No. 68	**DOB 8/07**	**DOD 8/07**	**Natural**
Age at death:	1 day old		
Substance exposed:	No		
Cause of death:	Osteogenesis Imperfecta		
Reason For Review:	Open preventive services case within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Infant was born with a severe form of the genetic disorder Osteogenesis Imperfecta (Brittle Bone Disease). He died in the hospital nine hours after his birth.

Prior History: The family's only DCFS involvement was a preventive services case that was open from April to September 2006 because of environmental concerns about the family's apartment. In June 2006, the mother and her 2- and 4-year-old children moved to a different home, correcting the environmental issues. The mother also participated in parenting education services and was linked to community resources.

Child No. 69	**DOB 10/91**	**DOD 8/07**	**Natural**
Age at death:	15 years old		
Substance exposed:	No		
Cause of death:	Sepsis		
Reason For Review:	Deceased was a ward		
Action Taken:	Preliminary investigation		

Narrative: Fifteen-year-old medically complex ward died in the hospital after being admitted three days earlier with overwhelming sepsis and multi organ failure. Among other problems, the ward had cerebral palsy, was mentally retarded, and suffered from chronic lung disease and seizure disorder. His foster mother, biological father, biological siblings, and other relatives were with him when he died.

Prior History: The family has a history of neglect dating to 2001. The ward and his three siblings entered foster care in 2003 after their mother was arrested for possession of methamphetamine and methamphetamine producing chemicals. The children's father surrendered his parental rights in 2004, and the mother died in 2005. The deceased's two younger siblings were adopted by separate families in 2006. His older sister remains in foster care and has a goal of independence.

Child No. 70	**DOB 11/03**	**DOD 9/07**	**Natural**
Age at death:	3-1/2 years old		
Substance exposed:	No		
Cause of death:	Cerebral palsy		
Reason For Review:	Open preventive services case within a year of child's death		
Action Taken:	Preliminary investigation		

Narrative: Twenty-eight-year-old mother awoke from a nap on a couch with her 3-1/2 year-old medically complex son, to find him unresponsive. She called 911, and the child was taken to the hospital where he was pronounced dead. At autopsy, the child looked well-cared for.

Prior History: In October 2006, the hotline was called with an anonymous report that the deceased, his 9-year-old sister, and his 7-year-old cousin were left home alone in a dirty house. The report was unfounded on the mother and expunged prior to the child's death. A preventive services case was opened, but closed two weeks later, in November 2006.

Child No. 71	**DOB 6/06**	**DOD 10/07**	**Natural**
Age at death:	16 months old		
Substance exposed:	No		
Cause of death:	Seizure disorder		
Reason For Review:	Pending DCP investigation at the time of infant's death		
Action Taken:	Investigatory review of records		

Narrative: Sixteen-year-old mother found her 16-month-old daughter unresponsive and called 911. The child was taken to the hospital where she was pronounced dead.

Prior History: In August 2007, a hospital social worker called the hotline alleging failure to thrive and medical neglect of a disabled infant. The infant had been born prematurely in a neighbor state and remained in the neonatal intensive care unit for two months. She was reported to have suffered a brain injury at birth and was severely delayed. While in the neighbor state, the mother was not referred to any additional services to help her child. Since moving to Illinois five months earlier, she was referred to early intervention services. The child had problems feeding, taking up to 45 minutes to drink a bottle, and doctors recommended that a g-tube be inserted to encourage weight gain and facilitate feedings. The mother was present at the hospital every day to care for her child, and medical staff felt she was appropriate with the child, but lacked resources. In September 2007, the child was discharged to her mother's care. They were living with the mother's boyfriend's grandmother. The child was going to be seen for continued care at a University clinic and was receiving in-home early intervention services. The investigation was ultimately indicated against the mother for substantial risk of physical injury because prior to the infant's hospital admission, the mother had not sought medical care for the infant's condition.

Child No. 72	DOB 4/00	DOD 10/07	Natural
Age at death:	7 years old		
Substance exposed:	No		
Cause of death:	Bronchial asthma		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Seven-year-old asthmatic child had been put to bed for the night, but he was coughing. His mother went to give him some cough syrup and he collapsed. In the past couple of months, the child was having increased difficulty with his asthma. He had had a nebulizer treatment earlier that day, and he had seen his doctor 2-1/2 weeks earlier.

Prior History: An intact family case was open from February 2002 through March 2003. It was reopened in March 2007 after the parents were indicated for substantial risk of physical injury because of ongoing domestic violence, primarily verbal altercations, between them. The intact family worker referred the parents for substance abuse treatment and domestic violence counseling, helped them locate new housing, facilitated a meeting with extended family, secured developmental services for the deceased's younger siblings, and discussed the deceased's asthma treatment plan with the parents. The case was closed in July 2008.

Child No. 73	DOB 10/06	DOD 10/07	Natural
Age at death:	Almost 1 year old		
Substance exposed:	No		
Cause of death:	Spinocerebellar Ataxia Type 7		
Reason For Review:	Open Preventive Services Case at time of child's death		
Action Taken:	Investigatory review of records		

Narrative: Infant, four days shy of her first birthday, died in the home of her maternal grandparents with whom she resided. The family had been working with hospice because the baby was born with a terminal illness, Spinocerebellar Ataxia Type 7, a genetic disorder which affects the central nervous system. The baby was blind, had no motor function, and had respiratory problems. The 25-year-old mother and 23-year-old father were concerned that there was mold and other possible toxins in their mobile home that were causing health problems for the baby, so they allowed the baby to live with the maternal grandparents while they looked for better housing. The infant was the parents' second child to die of the disease. Their first child died in March 2007. The children were only 11 months apart and the parents didn't know their first child had the illness when they conceived the second. The father also has the illness, which became apparent during his adulthood. The disease, when present in infancy, is fatal.

Prior History: In July 2007, a hospital social worker requested services for the family who were feeling overwhelmed, emotionally and financially, by the terminal illness of their second child so soon after the death of their first. DCFS opened a preventive services case. The worker obtained nursing services for the family until hospice could be put in place, made various referrals for the family, including housing advocacy, medical appointment transportation, and counseling. She visited the family weekly. Following the infant's death, the case remained open to get the parents into counseling and the mother's 3-year-old child into full-time Head Start. The parents became depressed, began drinking, and had marital difficulties. They eventually separated and the father moved to another city. The DCFS case remains open to monitor the surviving child. The maternal grandmother has expressed interest in obtaining guardianship of the child.

Child No. 74	DOB 7/07	DOD 10/07	Natural
Age at death:	Almost 3 months old		
Substance exposed:	No, however, mother has a history of substance abuse		
Cause of death:	Sudden Infant Death Syndrome		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Full investigation; report to Director 6/27/08		

Narrative: Twenty-nine-year-old mother found her 11-week-old infant unresponsive in the morning. The infant had been placed to sleep on her stomach on a flat pillow on a bed next to her mother. The mother and the infant were homeless and staying with the mother's boyfriend.

Prior History: The mother was sexually abused from the age of four to eleven by her father, and two uncles. From the age of nine to eleven she was prostituted by her mother. At age 11 she entered foster care. She was emancipated a week before her 18th birthday. In her six years as a ward, the mother lived in twenty-one different placements. From the age of 18 to 28, the mother had five children. From the age of 25 to 28, there were ten hotline reports involving the mother's children. The mother had a substance abuse problem. During the four years prior to the deceased's birth, the mother received long-term services from a domestic violence shelter and had an open intact family case. In August 2006, the children were adjudicated neglected per mother's stipulation, and the court awarded custody and guardianship of the children to the maternal grandmother. When the deceased was born, the hospital called the hotline with a report of substantial risk of physical injury because of the mother's history and because her four children were present unsupervised in the hospital while the mother gave birth. The family was staying in the shelter that mother had relied on for years. The investigation was unfounded and services were not offered to the family. The OIG investigation noted that the children in this family have health and behavioral issues that need to be addressed. Consequently, the Department located the family and initiated services. See Death and Serious Injury Investigation #7.

Child No. 75	DOB 8/87	DOD 10/07	Natural
Age at death:	20 years old		
Substance exposed:	No		
Cause of death:	Aspiration pneumonia		
Reason For Review:	Deceased was a ward		
Action Taken:	Full investigation, included in cluster report to the Director 9/22/08		

Narrative: Twenty-year-old severely medically complex ward was transferred to the hospital from his residential care facility because of upper respiratory problems. He died in the hospital four days later. He had a "do not resuscitate" order in place.

Prior History: The ward entered DCFS care at the age of 2-1/2 because of medical neglect. He was placed in a skilled nursing facility where he lived until his death. The ward's caseworker of eight years claimed to have made required monthly visits to the ward, but his claims could not be substantiated by objective means such as visitation logs, travel vouchers, or eyewitness reports.

Child No. 76	DOB 10/07	DOD 10/07	Natural
Age at death:	0		
Substance exposed:	Yes		
Cause of death:	Stillborn		
Reason For Review:	Open placement case (sibling in foster care)		
Action Taken:	Investigatory review of records		

Narrative: Thirty-one-year-old mother was taken to the hospital by paramedics because she was pregnant and bleeding. She had an emergency c-section. The infant, who was between 24-34 weeks gestation, never took a breath. The baby was believed to have been stillborn because of a combination of factors including untreated high blood pressure and drug use. The mother admitted to using cocaine and heroin.

Prior History: The mother, who was a ward as a child, has a history with DCFS as a parent dating to 1997 when she had her first child. Her three oldest children are all living with relatives pursuant to private arrangement. In July 2005, the mother gave birth to her fourth child. He was born substance-exposed, and the mother was indicated for substance misuse and substantial risk of physical injury. The infant was placed in foster care. At the time of the deceased's birth, the agency servicing the mother's case had not heard from the mother in almost a year. She had neither participated in services nor attended court hearings. The mother's parental rights to the child were terminated in March 2008. The father of the child signed specific consents for the foster parents to adopt the child, and his adoption is pending.

Child No. 77	**DOB 3/94**	**DOD 11/07**	**Natural**
Age at death:	13-1/2 years old		
Substance exposed:	Yes, cocaine		
Cause of death:	Chronic lung disease		
Reason For Review:	Child was a ward		
Action Taken:	Preliminary investigation		

Narrative: Thirteen-year-old medically complex ward died at the residential care facility where he had resided for nine years. The child suffered from cerebral palsy, seizure disorder, broncho-pulmonary dysplasia, and dyspepsia. He was non-mobile and non-verbal. He had a tracheotomy and required a gastric tube. The DCFS Guardian had signed a "do not resuscitate" order in 1998.

Prior History: The child's family first came to the attention of DCFS in 1992 when the 25-year-old mother's three children entered foster care because of neglect. In March 1994 the mother gave birth to the deceased at 31 weeks gestation. He tested positive for cocaine at birth and had multiple medical problems. He remained hospitalized for 14 months before being placed in a specialized foster home where he lived until moving to his residential care facility. The deceased's five siblings have been adopted; four by the maternal grandmother and the youngest by a paternal relative. The mother was not involved with the deceased child.

Child No. 78	**DOB 7/07**	**DOD 11/07**	**Natural**
Age at death:	4 months old		
Substance exposed:	No		
Cause of death:	Septic shock and metabolic acidosis		
Reason For Review:	Child of a ward		
Action Taken:	Investigatory review of records		

Narrative: Four-month-old infant, who was born prematurely, died in the hospital where she had been treated since birth.

Prior History: The deceased's mother has been a ward since she was 11 years old because of a history of abuse and neglect by her parents. The ward became pregnant with her first child, the deceased, when she was 18 years old. Her caseworker was aware that she was pregnant, and the ward was receiving prenatal care. She was put on bed rest two months prior to the infant's expected due date and was hospitalized for almost a week prior to the infant's premature birth. The ward has a goal of independent living. She gave birth to a healthy baby boy in September 2008.

Child No. 79	DOB 12/07	DOD 12/07	Natural
Age at death:	0		
Substance exposed:	Yes, cocaine		
Cause of death:	Neonatal demise (prematurity) due to presence of significant level of cocaine		
Reason For Review:	Open intact family case at time of infant's death		
Action Taken:	Investigatory review of records		

Narrative: Thirty-seven-year-old mother gave birth to an infant born at an estimated 25-29 weeks gestation. The baby died shortly after birth. The mother claimed she did not know she was pregnant, and she had no prenatal care. She tested positive for cocaine and admitted to using it. Toxicology results on the deceased infant were positive for cocaine metabolites.

Prior History: The mother gave birth to her first child exactly nine months earlier, in March 2007. The child was born at 31 weeks gestation and tested positive for cocaine. The mother was indicated for substance misuse, and an intact family case was opened. The mother was required to have a non-using adult live with her because the father was an over-the-road truck driver. The mother was referred to substance abuse treatment. Initially, the mother continued to use, but then she had a couple of months of sobriety, and the safety plan requiring that a non-using adult live with her was terminated. The mother then stopped going to treatment. In July a petition was filed in Juvenile Court, and in September the parents were placed on court supervision. When the deceased was born, the caseworker did not know the mother had been pregnant. The 9-month-old child entered foster care and was placed with his paternal grandmother. The mother was indicated for death by neglect and substantial risk of physical injury to the 9-month-old. In February 2008 the mother was incarcerated for possession of a controlled substance. She and the child's father surrendered their parental rights in March 2008 allowing the paternal grandmother to adopt the child.

Child No. 80	DOB 2/92	DOD 12/07	Natural
Age at death:	16 years old		
Substance exposed:	No		
Cause of death:	Cystic fibrosis and Neurofibromatosis		
Reason For Review:	Open intact family case within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Sixteen-year-old died in the hospital where he was being treated for cystic fibrosis and neurofibromatosis (a genetic disorder that causes tumors to grow on nerves and produce other abnormalities such as skin changes and bone deformities). The deceased was the third child in a sibship of six. His 12-year-old brother also has cystic fibrosis and neurofibromatosis. His 23-year-old and 10-year-old brothers have neurofibromatosis. Two of the siblings do not have either genetic disorder.

Prior History: In September 2006, the 9 and 11-year-old children's school called the hotline reporting injuries to the 11-year-old. Both boys reported that their 18-year-old sister hit them with a belt. The sister was indicated for cuts, welts, and bruises. The Department opened an intact family case to assist the family in meeting the needs of the four medically complex children. The 42-year-old mother's husband had died from a heart attack six months earlier. During the intact family case, the mother refused assistance from the Department and relied on community agencies and the hospital to meet the needs of her children. The children appeared well-cared for during visits. The mother assured the worker that the 18-year-old sibling would not discipline her brothers, and the intact family case was closed in June 2007.

Child No. 81	DOB 1/92	DOD 12/07	Natural
Age at death:	16 years old		
Substance exposed:	No		
Cause of death:	Seizure disorder due to cerebral palsy		
Reason For Review:	Child was a ward		
Action Taken:	Preliminary investigation		

Narrative: Foster mother checked on medically complex 16-year-old ward and found that she had vomited and was having trouble breathing. The foster mother called 911, and the child was transported to the hospital where she was pronounced dead.

Prior History: The ward entered foster care in 1996 when she was 4 years old. In 2002, her foster parents were in the process of adopting her when the foster father died, and the foster mother was unable to move forward on her own. The girl's second foster mother was in the process of adopting her when the child died.

Child No. 82	DOB 11/05	DOD 1/08	Natural
Age at death:	26 months old		
Substance exposed:	No, however, mother has a history of cocaine use		
Cause of death:	Salmonella Septicemia due to sickle cell anemia		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Two-year-old child died in the hospital from an illness resulting from untreated sickle cell anemia. She had been hospitalized for five weeks. According to hospital staff, the 20-year-old mother had medication for child, but did not give it to her. In September 2008, the mother was arrested and charged with involuntary manslaughter and endangering the welfare of a child. A surviving younger child lives with his 26-year-old father.

Prior History: The family's first involvement with DCFS was in July 2007 when the family physician made a child welfare services referral for the father of the deceased's younger brother. He was interested in obtaining custody of the child, for whom he had been caring. Within two weeks of that call, the physician called the hotline again with a report of medical neglect to the deceased because she had not received follow-up care for her sickle cell at a hospital in a neighbor state. The investigator confirmed that the mother had missed several appointments for the child. During the investigation, the investigator learned that the mother had moved to the neighbor state. The investigator contacted Children's Services in that state, and the mother was interviewed. She reported that she was in the process of obtaining a doctor to treat her daughter's condition. The investigation in Illinois was indicated and closed with a request that the neighbor state open a service case.

Child No. 83	DOB 11/06	DOD 1/08	Natural
Age at death:	14 months old		
Substance exposed:	Yes, cocaine		
Cause of death:	Meningococcemia		
Reason For Review:	Pending DCP investigation at the time of infant's death; open intact family case within a year of infant's death		
Action Taken:	Full investigation pending		

Narrative: Fourteen-month-old child was found unresponsive by his 38-year-old father and taken by ambulance to the hospital. The child was admitted with septic shock and cardiac arrest. He was revived several times. Doctors thought the child had meningitis. A toxicology screen revealed that the child's urine was positive for cocaine. It is unknown how the cocaine got into the child's system. The parents denied knowing. It could not be determined whether the child ingested the cocaine or inhaled it. The three siblings were screened and tested negative. The parents were indicated for poisoning, death by neglect, and substantial risk of physical injury to their children. The children came into foster care. Neither parent is complying with their service plan. The children were placed in a neighboring state with a maternal aunt under an Interstate Compact Agreement.

Prior History: The 33-year-old mother has given birth to eight children. The family has a history with DCFS dating to 1999 when extended family support services were used to help the maternal grandmother obtain guardianship of her three grandchildren. In March 2004, the mother gave birth to her fifth child. He tested positive for cocaine, and the mother reported using cocaine to relieve depression. The mother was indicated for substance misuse by neglect. An intact family case was opened, but closed in February 2005. While the mother had not successfully completed substance abuse treatment, the father was adequately meeting the children's needs. In November 2006, the deceased was born, testing positive for cocaine. The mother was indicated for substance misuse by neglect. A second intact family case was opened, and the mother entered inpatient treatment with the infant. She left treatment several weeks later and left the infant with her paramour. An investigation for inadequate supervision was initiated and later indicated against the mother. The father continued to care for the children while the mother came and left. The case was closed in September 2007, four months prior to the death.

Child No. 84	**DOB 3/01**	**DOD 1/08**	**Natural**
Age at death:	6-1/2 years old		
Substance exposed:	No		
Cause of death:	Cerebral Palsy		
Reason For Review:	Open intact family case within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: During the night, thirty-one-year-old mother checked on her 6-and-a-half-year-old child with cerebral palsy. She found him unresponsive and called 911. The child was taken to the hospital where he was pronounced dead.

Prior History: In April 2006, the mother took the child to the hospital because he was not eating. After a thorough investigation, the mother was indicated for medical neglect and malnutrition. The child had lost up to 4-5 pounds over three months and needed to have a g-tube placed. His mother had not sought medical care for him when he began losing weight. She appeared to take care of the child in all other ways. An intact family case was opened. The mother was cooperative with visits by the worker and a visiting nurse, and she made and kept medical appointments for the deceased and his siblings. The intact family case was closed in May 2007.

Child No. 85	**DOB 11/07**	**DOD 12/07**	**Natural**
Age at death:	6 days		
Substance exposed:	No, however, mother has a history of alcohol abuse		
Cause of death:	Complications from premature birth		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Six-day-old infant died in the hospital where he had been treated since his premature birth at 29 weeks gestation.

Prior History: In March 2007, the Department investigated a report of substantial risk of physical injury and cuts, bruises, welts to the 25-year-old mother's 7-year-old daughter. The girl told her teacher that her mother and grandfather had been drinking and got into an altercation. The girl showed her teacher a bruise that she said was caused by her grandfather. The investigation was unfounded because there was no history of domestic violence calls to the police, the girl told the investigator that she had lied to her teacher, the girl's credibility was questioned by the teacher and the school principal, and the mother, grandfather and an aunt denied that a physical altercation had taken place. The girl told the investigator that the bruise on her knee was from falling off her bike. Eight months after the infant's death, the grandfather called the police to report an incident of domestic violence involving the mother and her boyfriend. The police called the hotline. The mother and boyfriend were indicated for substantial risk of physical injury to the girl. The mother went into treatment for alcoholism and gave guardianship of her daughter to the aunt.

Child No. 86	**DOB 1/08**	**DOD 1/08**	**Natural**
Age at death:	15 days old		
Substance exposed:	No		
Cause of death:	Bronchopneumonia		
Reason For Review:	Child welfare services referral within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twenty-six-year-old mother laid her fifteen-day-old baby on her stomach on the bed beside the mother while she played with her 10-month-old son. The mother said she never left the room and when she turned to check on the infant, she was warm, but unresponsive. The mother called 911 and the infant was taken to the hospital where she was pronounced dead. The infant had been seen by her doctor for congestion four days earlier.

Prior History: Four months prior to the deceased's birth, in September 2007, a child welfare worker in a neighbor state called the hotline requesting services for the family. The mother had an open case in the neighbor state because of domestic violence. The mother had been cooperative with individual and domestic violence counseling. An Illinois worker spoke with the mother who reported that the domestic violence happened in the neighbor state, her youngest child's father (also the father of her unborn baby) was in jail there, and she decided to move away to Illinois. The mother was not interested in receiving services. She and her four children were living with her mother and maternal grandmother.

Child No. 87	**DOB 5/07**	**DOD 1/08**	**Natural**
Age at death:	8 months old		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Twelve-year-old girl took eight-month-old infant to bed with her, while her mother was at work. Later, her 13-year-old brother was searching for the television remote control and found the infant unresponsive. Overlay was considered as a cause of death, but the pathologist who conducted the autopsy concluded that SIDS was a more consistent cause of death. The infant was in the process of being adopted by the family pursuant to a private arrangement with the infant's mother, who was reported to be significantly developmentally delayed. A DCP death investigation was conducted. No one was indicated in the child's death, but the 34-year-old parents were indicated for environmental neglect because of the cluttered and dirty condition of the home. Services were offered to the family, but they refused them.

Prior History: A month prior to the infant's death, a paternal relative called the hotline alleging domestic violence between the parents, physical abuse to the children, and guns in the home which were in reach of the children. A child protection investigator was dispatched to the home immediately and was met by police, who searched the home for guns. The investigation was unfounded because no guns were found in the home, criminal history background checks were negative on both parents, the children did not have any observable injuries, and the children reported being treated well by their parents. The parents stated their belief that a paternal relative made the report in retaliation for a monetary claim they made.

Child No. 88	**DOB 11/07**	**DOD 2/08**	**Natural**
Age at death:	3 months old		
Substance exposed:	No		
Cause of death:	Sudden Infant Death Syndrome		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Three-month-old infant was found unresponsive. His 19-year-old mother had last seen him alive a few hours earlier. The infant had a digestive disorder, pyloric stenosis (a narrowing of the pylorus, the lower part of the stomach through which food and other stomach contents pass to enter the small intestine). The infant had undergone two stomach surgeries because of his condition.

Prior History: Two months earlier, the mother was investigated for cuts, bruises, and welts to the infant. The mother had taken the infant to the hospital for a pre-operative appointment. She had been up with the baby for several nights because he had been vomiting after feedings (a symptom of pyloric stenosis). While she and the baby were in the waiting room, hospital staff noticed the mother was very sleepy, and she was holding the infant. A nurse put the infant in his car seat and put the mother and infant in an examining room. The infant started crying and the mother picked him up to comfort him. She dozed off and the infant fell to the floor. A doctor was passing by the room and witnessed the infant fall. The infant was not injured, and the incident was determined to be an accident. The infant's regular physician redirected the mother not to hold the infant when she was so tired. The doctor described the mother as concerned about the child and reported that she kept all appointments for the child. The report was unfounded. The mother expressed interest in taking a parenting class, and the child protection investigator referred her to one.

Child No. 89	**DOB 12/07**	**DOD 2/08**	**Natural**
Age at death:	2 months old		
Substance exposed:	Yes, cocaine		
Cause of death:	Sudden Infant Death Syndrome		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Two-month-old ward was found unresponsive in his bassinette by his foster mother when she went to check on him in the early morning. The foster mother called 911 and began administering CPR. The baby was taken to the hospital where he was pronounced dead.

Prior History: The 24-year-old mother tested positive for cocaine when she gave birth to the deceased, her first child. The baby was not tested because the hospital missed collecting his first two urine outputs. The hotline was contacted. The mother admitted to using crack cocaine during the three to four days before giving birth. She said that she had been using for the last five to six years. The mother told the investigator that she wanted to keep her baby and was willing to enter inpatient treatment with the infant. An intact family case was opened. The mother and infant lived with the maternal grandmother while the mother waited to be accepted for treatment. Eleven days after the infant's birth, the mother was advised a spot had opened. The following day, the mother left the grandmother's home with the baby. The grandmother called the investigator five days later to report the baby was with her, but she could not assume responsibility for the baby because her daughter was violent, and she did not want to interact with her. The investigator took protective custody of the infant. He was placed in the licensed foster home where he died.

Child No. 90	**DOB 7/07**	**DOD 2/08**	**Natural**
Age at death:	7 months old		
Substance exposed:	Yes, cocaine		
Cause of death:	Hypoxic Ischemic Encephalopathy due to premature birth		
Reason For Review:	Open intact family case within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Seven-month-old infant was taken to the local hospital in cardiac arrest. She was resuscitated and transferred to a children's hospital where she died two days later.

Prior History The infant, who was an only child, was born at 28 weeks gestation, testing positive for cocaine and weighing only 2-1/2 pounds. The 29-year-old mother said she did not know she was pregnant so she did not receive prenatal care. She admitted to using cocaine. The mother was indicated for substance misuse. An intact family case was opened. The mother was living with her parents who planned to help care for the infant once she was released from the hospital. The mother visited the infant in the hospital regularly, but became depressed and started to discuss the possibility of placing the infant for adoption. In September, the mother gave guardianship of the infant to the maternal grandmother and moved to a neighbor state. The infant was released from the hospital in October 2007, and the intact family case was closed in November 2007.

Child No. 91	**DOB 8/06**	**DOD 3/08**	**Natural**
Age at death:	19 months old		
Substance exposed:	No		
Cause of death:	Bronchopneumonia		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Nineteen-month-old ward was found unresponsive in the morning by his foster mother. Paramedics were unable to revive him. The foster mother had checked on the child in the middle of the night, and he was fine. The foster mother was investigated, but unfounded for death by neglect and substantial risk of physical injury to another foster child and her grandchild who also lived in the home. An autopsy revealed the child died from bronchopneumonia, and the caseworker and a home service provider both reported that the foster parents took good care of the child.

Prior History: The deceased first came to the attention of DCFS when he was seven weeks old. His 22-year-old mother took him to the hospital with a fever. He was dehydrated and diagnosed with failure to thrive. The mother appeared to be on drugs and was inconsistent in her reports of how often and how much she fed the infant. The mother and infant lived with the infant's father and paternal aunt. The aunt agreed to be responsible for supervising and assisting the mother to care for the infant and his 5-1/2-year old sibling. The mother was indicated for non-organic failure to thrive and substantial risk of physical injury, and an intact family case was opened. Over the next few months, the caseworker made regular visits and completed referrals for homemaker services, counseling, and random drug screens. While the intact family case was open, the infant, then 7 months old, was burned over 60% of his body in a house fire started by his mother's negligence when putting out a marijuana cigarette. The mother and 19-year-old father did not immediately seek medical care for the infant, and he was not treated until two hours after the fire. The parents were charged with endangering the life of a child. The mother was indicated for burns by neglect, and both parents were indicated for medical neglect and torture. Both children were removed from their mother's care. The deceased remained hospitalized for six weeks and then received care at a residential facility. His foster parents visited him for two months learning to care for him before he went home with them in June 2007. The child received in-home physical and occupational therapy, and his foster mother took special care of his healing burns. A baby subsequently born to the parents in January 2008 was removed from their care because of their history and failure to participate in recommended services. That child currently has a goal of return home. The older sibling has a goal of substitute care pending court decision on termination of parental rights.

Child No. 92	**DOB 8/05**	**DOD 3/08**	**Natural**
Age at death:	2-1/2 years old		
Substance exposed:	No		
Cause of death:	Poorly differentiated malignant neoplasm of a group referred to as small round blue cell tumors, not otherwise specified		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		

Narrative: Two-and-a-half-year-old collapsed while being given a bath by his mother's 25-year-old boyfriend. The child was pulled from the bath and seemed okay. As he laid the child down for a nap, the boyfriend noticed he was not breathing and he called 911. The child was taken to the hospital where he was pronounced dead. The hospital called the hotline because he had bruises around his eye, on his arm, and along his forehead at the hairline. An autopsy revealed that the child had a rare form of childhood cancer in which tumors infiltrate the bones leading to a propensity for bleeding. A child protection death investigation was unfounded. The 24-year-old mother has a surviving 7-year-old.

Prior History: The boyfriend was indicated for cuts, welts, and bruises on a December 2007 hotline report involving his 4-1/2-year-old daughter. The girl's mother noticed that the child had bruising to her buttocks. The girl reported that her father spanked her. The father admitted spanking his daughter and described a red, yellow, and green light system for discipline. A green light meant the child got a sticker; a yellow light called for a warning and a 5-minute time-out, and read light meant a spanking. The child was able to describe the discipline system. The father agreed to extend the time-out instead of using spankings. Services were offered to the mother and the father (who lived in separate households), but neither was interested.

Child No. 93	DOB 7/93	DOD 4/08	Natural
Age at death:	14 years old		
Substance exposed:	No		
Cause of death:	Diabetic Ketoacidosis		
Reason For Review:	Pending DCP investigation at time of child's death; unfounded DCP investigation within a year of child's death.		
Action Taken:	Investigatory review of records		

Narrative: Fourteen-year-old collapsed on the living room floor of a friend's basement apartment and 911 was called. She was taken to the hospital where she was pronounced dead on arrival. The 14-year-old had a history of insulin-dependent diabetes and had been reported missing three days earlier by her mother. The girl was without her medication while she was away from home. She had a history of non-compliance with her diabetes medication management plan and had been hospitalized two weeks earlier because of it.

Prior History: In September 2007, the 14-year-old was hospitalized after she went missing for two days. The 40-year-old mother was investigated for medical neglect. The report was unfounded because the mother was trying her best to manage her daughter's diabetes, but her daughter refused to adhere to certain aspects of her management plan and ate food she knew she wasn't supposed to have. In March 2008, the hotline was called a second time when the child was hospitalized again for diabetic ketoacidosis. The child ran away for a few days to stay with friends because her mother would not allow her to see them. Whenever the child ran away, the mother would search for her and file missing person reports. When her daughter was found or called her in distress, the mother would take her straight to the hospital. She had lost jobs because of missing work to look for her daughter. The 14-year-old said it was not her mother's fault that she got hospitalized. While the investigation was still pending, the mother called the investigator to report that her daughter ran away the day before and a police report had been made. According to her doctors, the girl understood her illness and the severity of it, but like most teenagers, thought she would be fine. The mother sought help for her daughter, and the girl attended medical appointments in February and March. The investigation was unfounded.

Child No. 94	DOB 1/06	DOD 4/08	Natural
Age at death:	2 years old		
Substance exposed:	No		
Cause of death:	Bacterial meningitis		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Two-year-old ward was taken to the doctor by her foster parents. The doctor found the child to be dehydrated and hospitalized her the same day. Shortly after midnight, while being checked on by a nurse, the child was found to be unresponsive. Resuscitation efforts were unsuccessful.

Prior History: The ward entered foster care in September 2007 following her mother's second suicide attempt. The 26-year-old mother had health problems and was a childhood victim of sexual abuse by her father and grandfather. After three failed relative placements, the ward was placed in a non-relative foster home in November 2007. The ward was doing well in her placement. Her mother was working hard toward her return home, and the foster parents were supportive of that goal.

Child No. 95	DOB 1/05	DOD 5/08	Natural
Age at death:	3 years old		
Substance exposed:	No		
Cause of death:	Interstitial Lung Disease		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Three-year-old medically complex child died while hospitalized. A month earlier, the child had been diagnosed with Interstitial Lung Disease. His pre-adoptive foster parents and his biological parents were able to spend time with him before his death.
Prior History: The deceased was the second child born to his 34-year-old mother and 38-year-old father. The deceased entered foster care after his birth because of his biological parents' history of abuse and neglect. The parents surrendered their rights to the child, giving consent to the child's foster parents to adopt him. Earlier, the mother lost custody of her four older children from a prior marriage, and they were adopted by foster parents. The parents' first child together was already in foster care at the time of the deceased's birth. He is awaiting adoption by his foster parents.

Child No. 96	**DOB 5/08**	**DOD 5/08**	**Natural**
Age at death:	0		
Substance exposed:	Not tested, however, mother tested positive for cocaine		
Cause of death:	Stillborn		
Reason For Review:	Indicated DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
Narrative: Infant was born prematurely at 23 weeks gestation and never took a breath. The 25-year-old mother tested positive for cocaine at the time of the stillbirth.			
Prior History: In January 2008, the hotline was called with allegations of substantial risk of physical injury to the 1 and 2-year-old children of the mother and 24-year-old father because of the father's abuse of the mother. The parents denied domestic violence, but the investigator had copies of police reports that detailed a history of domestic violence. The parents were indicated for substantial risk of physical injury and were offered intact family services. The parents initially agreed to accept services, but then changed their minds. On the day they were to meet their worker, the mother reported that she was moving with the children to her father's home in the next two weeks. The father denied that he would be relocating with the mother and children. The worker disclosed the possible consequences, including losing custody of their children, if there were subsequent reports to the hotline. A month later, the father was incarcerated on a sentence for residential burglary. His projected parole date is July 2009.			

Child No. 97	**DOB 10/03**	**DOD 5/08**	**Natural**
Age at death:	14 years		
Substance exposed:	No		
Cause of death:	Complications of quadriplegia d/t tumor on spinal cord		
Reason For Review:	Unfounded DCP investigation within a year of child's death		
Action Taken:	Investigatory review of records		
Narrative: Fourteen-year-old quadriplegiac boy died at home while in the care of a home health care nurse.			
Prior History: In October 2007, the home health care agency called the hotline alleging that the 25-year-old mother had abandoned her son. The allegation was unfounded after an investigation revealed that the mother went out of town for the weekend to visit her ill father and arranged for the home health care agency (which provided almost 24 hours of respite daily) to care for the child in her absence. The agency subsequently called the mother to come home early because they could not fill a shift, but the mother did not return home until the prearranged time. A nurse remained with the child the entire time the mother was gone. The agency acknowledged that the mother took good care of her son.			

Child No. 98	DOB 11/06	DOD 5/08	Natural
Age at death:	1-1/2 years old		
Substance exposed:	No		
Cause of death:	Myocarditis		
Reason For Review:	Open intact family case at time of child's death		
Action Taken:	Full investigation pending		

Narrative: One-and-a-half-year-old child's grandmother noticed the child seizing in the afternoon. She called 911 and the child was taken to the hospital where approximately three hours later, he was pronounced dead. The deceased, his two older sisters, and his mother lived with the maternal grandmother. The mother was at work at the time of the incident.

Prior History: In February 2008, the 22-year-old mother reported to police that her 23-year-old husband put a gun to her head and fired three times. The gun never went off. The couple had been married for approximately two years and had two children together, ages 1 and 2. The mother also had a 5-year-old daughter from a previous relationship. The children were in the home at the time of the incident. The father was charged and convicted of aggravated assault and spent time in jail. The father was indicated for substantial risk of physical injury. The mother moved with her three children into the home of the maternal grandmother; both the mother and maternal grandmother agreed to not allow the father to have contact with the children. An intact family case was opened. The intact family case remains open, but the mother has not participated in recommended domestic violence counseling services. The father was released from jail in September, and the mother has been seeing him.

Child No. 99	DOB 10/91	DOD 6/08	Natural
Age at death:	16 years old		
Substance exposed:	No		
Cause of death:	Seizure disorder		
Reason For Review:	Child was a ward		
Action Taken:	Investigatory review of records		

Narrative: Sixteen-year-old ward was found unresponsive in the bathroom at her foster parent's home. She had gone in to take a shower and did not come out. 911 was called, and she was taken to the hospital, where she was transferred to a hospital with a pediatric intensive care unit. She was later placed on life support. Her parents signed a DNR, and she died the following afternoon. Toxicology tests detected the presence of her prescribed medications, but no illegal drugs or alcohol.

Prior History: The high school sophomore, who was an only child, became involved with DCFS six months prior to her death, in November 2007, when both of her parents, who shared custody, refused to allow her to return to their homes after the father dropped her off at the police station. The child had exhibited behaviors such as threatening her step-father with a knife, sneaking out of the house, and letting boys into her room late at night. She had been hospitalized in December 2006 and was prescribed medication. The child entered foster care and was placed in a foster home where she was doing well. The family was attending counseling. In May, while dining with her father, the child fainted and appeared to have a seizure. The child was taken to the hospital where tests were negative for seizure activity. She was scheduled to see a neurologist in June.

EIGHT-YEAR DEATH RETROSPECTIVE

TOTAL DEATHS BY CASE STATUS FY 2000 TO FY 2008

FISCAL YEAR	2000		2001		2002		2003		2004		2005		2006		2007		2008	
CASE STATUS	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Ward	29	31%	43	41%	23	24%	29	23%	31	22%	37	27%	17	20%	25	22%	19	19%
Unfounded DCP	7	7%	14	13%	7	7%	20	15%	29	21%	29	20%	25	29%	35	31%	18	18%
Pending DCP	10	11%	6	6%	8	8%	15	12%	12	8%	15	11%	7	8%	16	14%	13	13%
Indicated DCP	8	8%	14	14%	9	9%	12	10%	6	4%	1	1%	1	1%	6	5%	12	12%
Child of Ward	5	5%	4	4%	6	6%	12	10%	2	1%	2	1.5%	1	1%	4	4%	3	3%
Open Intact	9	9%	12	12%	20	21%	19	15%	15	11%	31	22%	20	23%	13	12%	18	18%
Closed Intact	5	5%	2	2%	8	9%	7	5%	13	9%	0	0	1	1%	2	2%	2	2%
Open Placement	3	3%	4	4%	5	5%	2	1.5%	10	7%	3	2%	2	2.5%	1	1%	3	3%
Closed Placement/ Return Home	3	3%	1	1%	4	4%	2	1.5%	2	1%	0	0	0	0	4	4%	1	1%
Split Custody	10	11%	0	0	4	3%	1	1%	7	6%	2	1.5%	2	2.5%	1	1%	1	1%
Others	7	7%	3	3%	3	4%	8	6%	12	10%	19	14%	10	12%	4	4%	9	9%
TOTAL	**96**	**100%**	**103**	**100%**	**97**	**100%**	**127**	**100%**	**140**	**100%**	**139**	**100%**	**86**	**%100**	**111**	**100%**	**99**	**100%**

CHILD DEATHS BY DCFS CASE STATUS AND MANNER OF DEATH

FISCAL YEAR	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total Deaths	**96**	**103**	**97**	**127**	**140**	**139**	**86**	**111**	**99**
Ward	**29**	**42**	**23**	**28**	**31**	**37**	**17**	**24**	**19**
Natural	13	20	14	18	16	28	10	13	11
Accident	6	9	3	3	3	1	2	6	5
Homicide	7	9	3	6	8	5	4	3	3
Suicide	0	0	3	1	2	3	0	0	0
Undetermined	3	4	0	0	2	0	1	2	0
Unfounded Investigation	**7**	**14**	**7**	**221**	**29**	**29**	**25**	**35**	**18**
Natural	0	5	2	9	16	17	8	9	6
Accident	2	6	0	6	8	8	8	16	7
Homicide	4	2	3	5	2	1	7	5	3
Suicide	0	0	1	0	0	0	0	1	1
Undetermined	1	1	1	1	3	3	2	4	1
Pending Investigation	**10**	**6**	**8**	**15**	**12**	**15**	**7**	**16**	**13**
Natural	0	1	7	6	6	4	3	8	3
Accident	5	1	1	3	1	5	2	2	1
Homicide	3	3	0	5	3	3	2	4	3
Suicide	0	0	0	0	0	0	0	0	2
Undetermined	2	1	0	1	2	3	0	2	4
Indicated Investigation	**8**	**14**	**9**	**12**	**6**	**1**	**1**	**6**	**12**
Natural	1	4	7	7	3	1	0	2	4
Accident	4	7	0	4	3	0	0	4	2
Homicide	1	1	1	0	0	0	0	0	4
Suicide	0	0	0	0	0	0	0	0	0
Undetermined	2	2	1	1	0	0	1	0	2
Child of Ward	**5**	**4**	**6**	**12**	**2**	**2**	**1**	**4**	**3**
Natural	1	1	1	6	1	2	1	2	1
Accident	1	1	2	3	1	0	0	0	1
Stillbirth	2	0	0	0	0	0	0	0	0
Homicide	0	0	2	2	0	0	0	0	1
Suicide	0	0	0	0	0	0	0	0	0
Undetermined	1	2	1	1	0	0	0	2	0
Open Intact	**9**	**12**	**20**	**19**	**15**	**31**	**20**	**13**	**18**
Natural	6	6	6	4	8	23	12	5	6
Accident	0	5	7	10	1	5	3	4	4
Homicide	1	1	5	1	1	2	4	2	4
Suicide	0	0	0	0	1	0	0	0	1
Undetermined	2	0	2	4	4	1	1	2	3

FISCAL YEAR	2000	2001	2002	2003	2004	2005	2006	2007	2008
Closed Intact	**5**	**3**	**8**	**7**	**13**	**0**	**1**	2	2
Natural	2	2	2	3	3	0	0	1	2
Accident	2	0	4	1	5	0	1	1	0
Homicide	1	0	0	3	4	0	0	0	0
Suicide	0	0	0	0	0	0	0	0	0
Undetermined	0	1	2	0	1	0	0	0	0
Open Placement	**3**	**4**	**5**	**2**	**10**	**3**	**2**	**1**	**3**
Natural	3	2	4	2	9	2	2	1	3
Accident	0	0	0	0	0	0	0	0	0
Homicide	0	0	0	0	1	1	0	0	0
Stillbirth	0	2	0	0	0	0	0	0	0
Suicide	0	0	0	0	0	0	0	0	0
Undetermined	0	0	1	0	0	0	0	0	0
Closed Placement	**3**	**1**	**4**	**2**	**2**	**0**	**0**	**0**	**0**
Natural	3	0	3	1	1	0	0	0	0
Accident	0	1	0	0	0	0	0	0	0
Homicide	0	0	1	1	1	0	0	0	0
Suicide	0	0	0	0	0	0	0	0	0
Undetermined	0	0	0	0	0	0	0	0	0
Split Custody	**10**	**0**	**4**	**1**	**7**	**2**	**2**	**1**	**1**
Natural	0	0	2	1	3	1	1	0	1
Accident	1	0	0	0	2	1	1	0	0
Homicide	1	0	1	0	2	0	0	0	0
Stillbirth	3	0	0	0	0	0	0	0	0
Suicide	0	0	0	0	0	0	0	0	0
Undetermined	5	0	1	0	0	0	0	1	0
Adopted	**0**	**2**	**2**	**1**	**1**	**0**	**0**	**0**	**0**
Former Ward	**5**	**1**	**0**	**1**	**1**	**0**	**1**	**1**	**1**
Open Return Home	**0**	**0**	**0**	**1**	**0**	**3**	**0**	**4**	**1**
Closed Return Home	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Homicide by a ward	**1**	**0**	**1**	**2**	**0**	**0**	**0**	**0**	**0**
Interstate compact	**0**	**1**	**0**	**0**	**1**	**0**	**1**	**0**	**0**
Preventive services	**0**	**0**	**1**	**3**	**4**	**13**	**5**	**2**	**3**
Subsidized Guardianship	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**
Child of former ward	**0**	**0**	**0**	**0**	**3**	**1**	**0**	**0**	**0**
Extended family support	**0**	**0**	**0**	**0**	**2**	**2**	**0**	**1**	**0**
Child Welfare Referral	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**1**	**5**

GENERAL INVESTIGATIONS

GENERAL INVESTIGATION 1

ALLEGATION A child protection investigator failed to perform her professional duties and misused her authority when she instructed the father of a three year-old boy to return the child to his mother, the subject of a pending abuse report.

INVESTIGATION The boy's father and paternal grandmother observed large circular bruises on the boy's hip after he was dropped off by his mother for a visit. The father transported the boy to his family physician for an examination and then to the local police department. The boy consistently stated the injury had been caused by his mother hitting him with a wooden spoon. A sergeant told the father to keep the boy with him until a detective could venture to the mother's home to assess the situation. A hotline call was made and a child protection investigator was assigned to the case.

As the case was being opened, the child protection investigator's supervisor received a call from the mother's attorney demanding the boy be returned to the mother immediately, in compliance with a standing court order related to the couple's ongoing custody battle. The supervisor contacted the investigator and told her to determine whether law enforcement intended to arrest the mother or take protective custody of the boy. After learning the police had not yet resolved to pursue either course of action, the investigator asked police to instruct the father to return the boy to his mother. Neither the investigator nor her supervisor ever viewed a copy of the court order, nor did they observe the boy prior to insisting that he be returned to the mother's home. In an interview with the OIG, the investigator said she did not perform a risk assessment before advocating for the boy's return to his mother because, "the police assess risk" and had not decided to pursue criminal charges at that time. In his interview with the OIG, the supervisor stated the OIG interviewer did not possess a requisite understanding of investigations and court orders to comprehend his rationale for supporting the boy's return. During the interview the supervisor made disparaging remarks regarding the father, questioning the credibility of his statements and the photos he provided of his son's injury, without providing any basis for doing so.

The day after the report was made, the investigator was present at the police department when the father arrived with the boy to return him to his mother. The investigator told the OIG she attempted to speak to the father at that time, however he refused to consent to an interview. While interviewing the boy at the police station, the investigator learned he played games involving tumbling and roughhousing with other children while at his father's home. The investigator then asked the boy a leading question as to whether he had been playing these games when he was injured, to which the boy responded affirmatively. When asked if she had explored the possibility the father might have caused the injuries, the investigator stated the father's refusal to speak with her made such an inquiry impossible. The investigator never interviewed the paternal grandmother even though she had originally received the boy when the mother dropped him off and had been listed in the hotline report as an Other Person With Information (OPWI). A review of the investigator's case notes found that she routinely classified both face to face and telephone contacts as having taken place "in person" and frequently consolidated multiple contacts into single entries, making it difficult to ascertain the true nature of these communications. In addition, the investigator repeatedly provided information to the OIG which was vital to understanding her handling of the case that had not been included in her notes.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be counseled regarding the necessity to assess child safety first and foremost,

even when families have custody papers or other court orders. The investigator should cease her practices of (1) identifying phone contacts as "in person" contacts when she initiates a phone call, (2) omitting important information gathered during contacts from contact notes, and (3) recording in a single contact note, multiple contacts or investigative activity that occurs at more than one location.

The employee was counseled.

2. The child protection investigator's supervisor should be considered for non-disciplinary counseling and review this report.

The employee was counseled.

3. The Office of the Inspector General reiterates its recommendations made in previous reports in June 2006 and May 2007 that prompting questions and guidelines be developed for child protection investigators as to how information should be shared when seeking an opinion from a doctor about physical injuries.

A memo, *Minimum Requirements for SOR Conference Calls*, was issued to staff July 23, 2007. Part 1 of this memo details questions to be asked prior to the completion of a child protection investigation. Part 2 of this memo includes 13 prompting questions to be used when physical injury is being investigated. Several of the prompting questions apply directly to when an opinion of medical professionals on risk/protection is being sought.

GENERAL INVESTIGATION 2

ALLEGATION

A child protection investigator violated a consent decree by failing to arrange for the services of an interpreter while handling a case involving a non-English speaking family.

INVESTIGATION

The child protection investigator was assigned to a case involving possible physical abuse of a six year-old girl who arrived at school with a bruise on the side of her face. The investigator began her work on the case by going to the school and interviewing the girl's two brothers, ages eight and nine, who denied any abuse in the home. Although the initial report contained a statement by the nine year-old that his sister had previously been hit in the face with a ruler by their paternal grandmother, the investigator did not ask the boy about the allegation. The investigator then went to the home of the girl's mother and attempted to interview the girl. The girl did not speak English so the investigator accepted an account of the incident from the girl's father, who was divorced from the mother and did not live in the home. The father stated he had been spinning his daughter around and after he set her down she was dizzy and walked into a wall. The investigator then interviewed the mother, who also did not speak English, with the father serving as an interpreter. Through the father, the mother stated she was not present when the incident took place and had no knowledge of the event. Based almost entirely on her interaction with the family, the investigator subsequently recommended unfounding the report and the decision was approved by her supervisor.

In her handling of the case, the investigator failed to perform many of the duties required to gain an accurate understanding of events and family dynamics. Most glaringly, the investigator did not utilize Department resources to obtain the services of a translator in order to communicate directly with the girl, the alleged victim, and her mother. The investigator never interviewed the girl, relying instead on the father's description of the injury as being accidentally self-inflicted. The investigator never conducted background checks on the parents or search for a family history with the Department through the State Automated Child Welfare Information System (SACWIS). If she had, she would have learned that five years earlier the father had been indicated for physical abuse of the then one year-old girl for hitting her with a hot spatula after she soiled her pants. The investigator never conducted necessary interviews with either the reporter or the alleged perpetrator, the paternal grandmother. The investigator also never conducted a visit to the father's home where the incident occurred. In an interview with the OIG, the investigator acknowledged she had been instructed by her supervisor to contact the Department's language line to secure an interpreter but neglected to do so.

The investigator's supervisor was woefully inadequate in her oversight of work on the case. Although she told the investigator to utilize a translator she did not ensure the investigator carried out the directive. Following the investigator's visit to her home, the mother contacted the Department's Advocacy Office to express her concern that the father had not been entirely accurate and forthright while serving as a translator. Despite being alerted to the mother's desire to conduct another interview, the supervisor did not take steps to guarantee the meeting occurred. Furthermore, the supervisor approved the completion of an investigation in which numerous required tasks were not performed.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be disciplined for failing to interview the victim, in lieu of interviewing the alleged victim, accepting the explanation of an indicated perpetrator without question, failing to conduct a criminal background check, failing to interview the reporter and failing to interview the alleged perpetrator. The investigator should also be disciplined for failing to arrange the interpreter services for a Spanish speaking mother and alleged child victim in violation of

the Burgos Consent Decree.

The Department agrees. The disciplinary process has been initiated.

2. The child protection investigator's supervisor should be disciplined for approving an investigation even though the reporter had never been interviewed, the alleged child victim had never been interviewed and after being requested by the Advocacy Unit to obtain interpreter services, failing to ensure that interpreter services were arranged for a Spanish-speaking mother and the alleged child victim in violation of the Burgos Consent Decree.

The Department agrees. The disciplinary process has been initiated.

GENERAL INVESTIGATION 3

ALLEGATION

A child protection investigator removed a 16 year-old from the custody of her mother without proper authorization or consent.

INVESTIGATION

The girl was taken to a hospital by staff from her school after injuries were observed on her body. The girl stated she was afraid to return to her mother's home because she endured frequent physical abuse and expressed an intention to run away to live with her father in another state. A child protection investigator was assigned to the case and went to the family's home and interviewed the mother. In an interview with the OIG, the investigator described the mother as "combative and upset, ranting and raving," and said she refused to provide any information about the family. The investigator was familiar with the family's history of three prior unfounded reports alleging abuse of the girl by the mother and had investigated one of the reports. The investigator then contacted the hospital and was informed the treating physician had concluded the girl's injuries were the result of abuse. The hospital had identified the girl's maternal aunt as a caretaker and the investigator consulted with her supervisor over the phone regarding developing a safety plan. The investigator was also provided with contact information for the girl's father but did not attempt to speak with him.

The aunt agreed to take the girl home with her and transported her from the hospital. The investigator then called the mother who refused to agree to a safety plan and demanded that her daughter be returned immediately. The investigator went to the aunt's home and met with her and the girl. While she was there, the mother arrived outside and pounded on the door, threatening to kill the aunt. Police were called to the home and spent one hour intervening in the situation before persuading the mother to go home. The safety plan developed by the investigator was invalid, as safety plans require the consent of the parent. While the father could have agreed to the safety plan, this resource was not utilized. Neither the investigator nor her supervisor recognized that the circumstances of the situation; confirmed abuse, the victim's fear of returning home and threats of violence by the mother, met the criteria to take the girl into protective custody. In an interview with the OIG, the investigator's supervisor stated she was aware of the family's history but since the previous reports had been unfounded, she viewed the latest episode as an "initial" report and believed an additional burden of proof would be required before protective custody could be taken. Both the investigator and her supervisor demonstrated a poor understanding of distinguishing when either a safety plan or protective custody was appropriate. The supervisor stated she was unaware the mother had not consented to a safety plan when she reviewed an electronic document prepared by the investigator, although the investigator had checked a box provided indicating exactly that. The presence of the box denoting an absence of parental consent for a safety plan could mislead investigators into believing they could implement a plan without parental approval.

The investigator and her supervisor did not meet to discuss the case for five days. In the interim, the mother went to the Department field office and confronted the supervisor, again demanding the return of her daughter. The supervisor felt sufficiently threatened to call for office security to monitor the meeting but still did not recognize the need to take protective custody of the girl, despite her realization the mother had not agreed to the safety plan. Unbeknownst to the supervisor, the mother, and the investigator, the girl had run away from her aunt's home. The girl left a note saying she had fled in fear of retaliation from her mother and was attempting to reach her father's home out of state. The girl later returned to the area and was placed in the home of another relative. The report against the mother was indicated for abuse.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be disciplined for failing to take protective custody of the girl.

The investigator received a written reprimand.

2. The child protection investigator's supervisor should be disciplined for failing to ensure that protective custody was taken and failing to act when she learned that the mother had not consented to the safety plan.

The supervisor received non-disciplinary counseling.

3. The third check box option on the Safety Plan screen of the SACWIS Safety Assessment should be removed because it provides child protection workers with an option that conflicts with Rule and Procedures 300.

The Department agrees. Representatives from the Department's Safety Workgroup and representatives from the SACWIS workgroup are reviewing the recommendation for implementation.

4. Several OIG investigations have disclosed that the field continues to ignore fathers. The Department should review existing Rules and Procedures to determine where specific directives should be included to require consideration of fathers as caregivers. The Department should administer remedial training around this issue to create a change in behavior.

This issue is imbedded in the reunification training conducted in all regions. This issue is also included in the pre-service curriculum for child protection staff.

GENERAL INVESTIGATION 4

ALLEGATION

A child protection investigator abused her authority by insisting a couple allow their three children to live with their aunt in another state after the investigation of the family had been closed.

INVESTIGATION

A child protection investigation of the family commenced after concerns were raised over the parents' fitness and their ability to care for the children, a 12 year-old boy and girls ages 8 and 6. The parents had isolated themselves from friends and family who made statements suggesting they were out of touch with reality or unable to care for their children. Their inability to provide consistent support to their children resulted in the children missing a significant number of school days and mounting financial woes threatened to force the family from their home. The family had recently moved to Illinois from another state.

The child protection investigator ultimately indicated the report against the parents for inadequate shelter, due to the uncertainty of their ability to remain in their home, and closed the case. The investigator closed the case without contacting the child protective services agency in the family's home state to determine if there had been any previous involvement. In addition, despite stated concerns regarding the parents' mental fitness, the investigator never contacted the family's mental health provider. Both parents had previously signed consents found in the case file allowing for communication with their care providers and for release of their mental health records. An OIG review of the parents' mental health records found they had been consistently compliant with some services and had reported progress after being prescribed medication. The children's attendance at school, however, had not improved. Following case closing, the family was referred for intact services.

Three days after the case was closed, the mother called the intact worker following a verbal confrontation at her home with the truancy officer from the children's school. The intact worker and the investigator went to the home in an attempt to secure the mother's consent to speak with relatives from the family's home state, however the mother refused. The following day the intact worker and the investigator consulted with the investigator's supervisor. The intact worker and the investigator then met with the intact worker's supervisor and program manager. During the meeting the group contacted the mother's relatives who agreed to travel to the family's home and take the children back with them out of state. The plan was formulated without the parent's knowledge or consent and no call was placed to the hotline to report potential risk to the children.

After the relatives arrived from out of state, the investigator contacted police for assistance and met all parties at the family's home. The investigator presented the parents with an ultimatum that they either allow the relatives to take the children with them or they would be placed in foster care. The parents relented and the mother accompanied the children and her relatives out of state. The day after leaving Illinois, the mother learned the father had threatened suicide and returned to be with him. She left the children in the custody of their maternal grandparents and provided them with the children's medical cards and a note authorizing them to receive treatment if necessary. After learning the mother had left the children, the investigator contacted child protective services in the family's home state and alleged the parents were homeless, suffered from mental illness and had abandoned their children.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be disciplined, up to and including discharge, for violating Abused and Neglected Child Reporting Act and taking custody of children without authority. In addition, she should be disciplined for her failure to obtain mental health records, interview mental health professionals and inappropriately intervening in an intact family services case.

The investigator received a one-day suspension.

2. A redacted copy of this report should be shared with the intact services supervisor and program manager.

The redacted report was shared with the supervisor and manager.

3. The Department should adapt questions found in the book authored by Teresa Ostler, *Assessment of Parenting Competency in Mothers with Mental Illness* for child protection investigators to utilize when interviewing mental health professionals to determine a parent's ability to adequately care for his/her children. These questions should be incorporated into child protection investigator training.

The Department agrees. The Department's Safety Workgroup is reviewing the questions to determine how best to incorporate the material into training.

GENERAL INVESTIGATION 5

ALLEGATION

A private agency caseworker failed to adequately investigate a report that a foster mother was receiving board payments for three children not in her care.

INVESTIGATION

A foster mother dropped off a sibling group of three foster children, ages 10, 8, and 7, at the home of their relative days after the children were placed in the foster mother's care. The private agency case manager responded to reports of this arrangement and removed the children from their relative's care only after being confronted by court personnel nearly four months later. The children were removed from the home they shared with their grandmother and mother after their mother was indicated for abuse. At the time the children were taken into protective custody, the grandmother admitted to having an addiction to heroin and was ruled out as a viable placement. The case was assigned to a private agency and the children were placed at the agency's Safe Home for Kids house with a licensed foster parent. Safe Home for Kids is a municipal initiative that provides single-family homes to private agencies for the purpose of reuniting/keeping together sibling groups who are under the care of the Department. On her own accord, the foster mother took the children to the aforementioned grandmother's home three days after they were placed in her care. The children resided with their grandmother while the foster mother collected board payments and lived rent free in the Safe Home.

The foster mother would arrange for the children to return to the Safe Home for scheduled appointments. The case manager did not conduct unannounced visits to the Safe Home nor did she see the children at school. In early February, the children's father reported to the case manager that the children were living with their grandmother and she did nothing with this information. In late March following a court hearing court officers learned that the children were residing with their grandmother instead of the licensed foster home. Acting upon a directive from the children's attorney the case manger interviewed the children at school about their living arrangements and they disclosed that they had lived with their grandmother since Thanksgiving. The children's grandmother came to school to pick-up the children and confirmed that the foster mother left the children in her care. The children were then placed in another traditional foster home and at this time a series of placement disruptions began.

The investigation revealed that the private agency case manager did not properly monitor this case, provide services, or maintain documentation of visits or services in the case file. The case manager falsely testified in court that she saw the children in February immediately after the father first told her the children were living with their grandmother. Because of her dereliction of duty the children were placed at great risk and the family's progress was hindered. The private agency supervisor was also negligent in that she did not adequately monitor the work of the case manager. Consequently, the family was not provided with the services that the agency was contracted to provide.

The private agency's licensing worker did not follow through with licensing enforcement after licensing violations were substantiated and the foster mother failed to cooperate with a corrective action plan. Although the foster mother left the home upon the agency's request, her license remained active.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency should consider disciplinary action of the caseworker, up to and including discharge, for failing to immediately and thoroughly investigate the father's report that he saw the children with the maternal grandmother, for falsely testifying in court about when she first learned the children were seen unsupervised with the grandmother and her response to the report, for failing to file licensing complaints when she learned of alleged incidents of corporal punishment in two licensed foster homes, for providing false information to OIG investigators, and for failing to provide

needed case management services to the family in accordance with the agency's personnel policies.

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

The caseworker was discharged.

2. The private agency should consider disciplinary action of the caseworker's supervisor for her failure to ensure the caseworker provided the family with required case management services in accordance with the agency's personnel policies.

The supervisor was disciplined.

3. The Department's Agencies & Institutions Licensing Liaison assigned to the private agency should provide training to the licensing worker on conducting licensing complaint investigations and enforcement procedures.

The Licensing Liaison was un-responsive to requests from the private agency for training. The Office of the Inspector General shared a redacted report with the Licensing Liaison's supervisor to compel a response from the Liaison.

4. The private agency should proceed with revocation of the foster mother's foster home license citing all applicable violations of 402 Licensing Standards for Foster Family Homes and Child Care Act of 1969.

License revocation proceedings have been initiated.

5. This report should be shared with the Executive Director of the private agency for file review of all of the caseworker's case assignments.

The report was shared. The caseworker's case assignments were reviewed by the Director of Foster Care.

6. This report should be shared with the assigned Department Agencies & Institutions Licensing Liaison for counseling with the private agency's licensing worker and her supervisor.

The licensing worker and supervisor were counseled. The licensing worker attended a licensing training offered by the Department.

7. The private agency should conduct a diligent search for the man who was named as the 10 year-old boy's father.

The private agency completed a diligent search for the father but no one has come forward.

8. A referral for psychiatric consultation should be made immediately for the seven year-old boy.

The boy received a psychiatric evaluation.

9. The private agency should inquire about an educational case study for the eight year-old boy as recommended by the Child and Youth Investment Team.

The private agency requested an educational case study.

10. The private agency should actively reach out to the mother to ensure the safety of her baby who is due in June 2008.

The baby, born on June 17, 2008, was initially left in the mother's care.

11. The Office of the Inspector General will notify the Commissioner of the City of Chicago Department of Housing, of the need to review the Operating Agreement of the Safe Homes for Kids program between the City of Chicago and the private agency for possible violations of the agreement.

The Inspector General met with the Commissioner of the City of Chicago Department of Housing to discuss the Safe Homes for Kids program. The Inspector General agreed to review licensing compliance status of the foster families residing in the Safe Homes for Kids.

GENERAL INVESTIGATION 6

ALLEGATION

A child protection investigator failed to contact the reporter of allegations of inappropriate contact between two minor boys.

INVESTIGATION

The investigator was assigned to respond to allegations that an 11 year-old boy had exposed himself to two neighbor boys, ages 6 and 7, and touched the 7 year-old on the groin over his clothes. Two weeks after the initial report was made, the same reporter contacted the hotline and stated the 11 year-old's 6 year-old sister had made statements against him alleging the boy had touched her inappropriately and had engaged in sexualized behavior with a friend and the family's dog. That report was assigned to the same investigator. After completing her work on the cases the investigator recommended to unfound both reports. The decision was approved by the investigator's supervisor.

In her work on these cases the investigator demonstrated a lack of thoroughness and urgency. After making initial "good faith" efforts to meet the family on the day she accepted the case, the investigator took no further action until two weeks later when the second hotline call was made. In response to the second report the investigator conducted interviews with the 11 year-old boy and his parents. Following the interviews, the investigator simultaneously completed Child Endangerment Risk Assessment Protocols (CERAP) for both the first and second reports that were identical in language and listed the 6 and 7 year-old brothers as being unavailable for assessment. The investigator also did not contact the reporter until after the second report had been made and failed to verify information provided by the parents with the boy's school.

The investigator failed to enter pertinent information in the State Automated Child Welfare Information System (SACWIS) in a timely fashion, which hampered the ability of her supervisor to effectively monitor her progress. In an interview with the OIG, the supervisor stated the investigator provided her with verbal updates of the cases' status during meetings and asserted she had performed all necessary interviews. The failure of the investigator to record her interviews in the SACWIS system prevented the supervisor from recognizing that a period of 30 days had elapsed between contacts while the cases were pending. Although the supervisor instructed the investigator to update her SACWIS entries and required her to dedicate two hours a day towards making them current, the investigator was unable to bring her entries up to date.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be disciplined for her failure to make and document required contacts in a timely manner.

Discipline is in progress.

2. The child protection investigator's supervisor should conduct weekly scheduled supervision with the investigator to address her investigative deficiencies.

Supervision is being completed with the employee.

GENERAL INVESTIGATION 7

ALLEGATION

A child protection investigator failed to inform a private agency of a pending abuse investigation involving a foster mother licensed through the organization.

INVESTIGATION

The investigator was assigned to the case after it was alleged the mother had physically abused her 11 year-old adoptive daughter by burning her hand. The report taken by the hotline noted the possibility the mother was a foster parent. An OIG review of the case file found 12 days had elapsed before the investigator met with the girl or her 10 year-old sister who also lived in the home. Although the investigator had been informed the girls went to a residential day care provider after school, he repeatedly attempted to visit the girls at their home at a time when no one would be present. Both the injured girl and her sister denied being abused by their mother and provided a conventional explanation for the wound. The investigator did not complete a Child Endangerment Risk Assessment Protocol (CERAP) to gauge and record the children's safety in the home. In an interview with the OIG, the investigator stated that after he spoke to the girls and concluded the reporter was not credible, he determined the girls were not at risk and saw no need to complete the form.

The investigator was not aware that a five year-old male foster child also resided in the home until one month after the report was taken when he was contacted by staff from the private agency handling the boy's case. At the time of the initial investigation the boy had been hospitalized and was not present in the home. In his interview with the OIG, the investigator acknowledged he had never consulted the Department's Child and Youth Centered Information System (CYCIS) to determine whether the mother was a foster parent or had any children placed in her home, although he had been instructed to do so by his supervisor. The abuse report against the mother was ultimately unfounded and the five year-old boy was allowed to return to the home.

An OIG review of the investigator's case load during the time period found the number of cases he was responsible for exceeded the limit established by the Department to maintain adequate case service and supervision.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should be disciplined for failing to notify the Department's licensing division or the private agency of the pending child protection investigation. The discipline should be mitigated by the fact that the investigator's caseload was higher than permitted by the B.H. consent decree for three months, including the time period in question.

The Department has initiated the disciplinary process.

GENERAL INVESTIGATION 8

ALLEGATION

During testimony to the Department's Oversight Legislative Committee, the Cook County Public Guardian criticized the Department for unfounding an abuse investigation despite a video that clearly showed a residential facility worker striking a developmentally delayed resident.

INVESTIGATION

The 14 year-old disclosed to a staff member that one of the residential workers had hit her knee with the plastic arm of a chair. The staff member observed the mark on the youth's knee but was skeptical that it had been caused that morning and did not believe it looked consistent with a mark that would have been left by a rectangular chair arm. She reported the disclosure to the girl's therapist. The therapist and a unit supervisor spoke to the girl the next day, but did not attempt to observe the injury. The facility did not arrange to have the youth examined by the nurse and there was no medical documentation of her injury. The hotline was not called until four days after the incident, when the facility was able to review the tape of the incident. The allegation was accepted for an investigation of Cuts, Welts and Bruises. When the hotline was called, the residential facility worker had already been discharged from the facility. The mandate investigator interviewed the 14 year-old victim, but failed to determine if she had any injuries – other than by asking the girl, who denied that she had any injuries. By the time the full investigator was assigned, there was no mark on the girl's knee. The only documentation of the mark was a note created by the girl's caseworker seven days after the event and the description of the mark differed from the description provided by the person to whom the youth had first disclosed. The youth had recanted her disclosure when interviewed by child protection and failed to disclose anything during a victim sensitive interview conducted at the local child advocacy center. The tape of the incident showed the worker attempting to handle the girl during a tantrum. The Unit was short one staff member and while the policy of the facility required that a single staff member should never attempt to place a child in a restraint, there were no available staff to assist. At one point, while sitting in a chair to prevent the youth from leaving her room, the youth began kicking the worker who can be seen swinging the piece of plastic at her leg. The tape then shows him picking up the youth and carrying her to the "Quiet Room."

Between the incident and the date that the investigator noted that no bruise was visible approximately one week had passed. During that time, the youth had been restrained five times, both at school and at the facility and had gotten into a fight at school with another student. The morning of the incident, she had been restrained by another staff member in a manner that had resulted in a red mark on her neck that was documented by the school. In addition, while the youth was seen by medical staff for other reasons during the time that the mark would have been visible, medical staff never noted an injury to her knee, though they appeared to be thorough in noting other injuries.

While the residential worker's actions were inappropriate, the OIG did not find that the child protection worker engaged in misconduct by unfounding the investigation. To indicate an allegation of Cuts, Welts and Bruises, the investigator must be able to document a mark left by the action of the alleged abuser. Here, the youth's recantation, along with the inadequate documentation of injury supported a decision to unfound the allegation.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The mandate investigator should be counseled on his failure to independently document the presence or absence of an injury.

The Department agrees. The investigator will be counseled.

2. The investigator should review this report with her supervisor to inform future investigations of

abuse allegations in residential facilities.

The report was shared with the employee.

3. The facility should regularly review Quiet Room tapes to ensure that the proper restraint procedures are used and to ensure that restraints are properly documented.

The Office of the Inspector General shared a redacted copy of the report with the private agency. The Inspector General met with agency Administrators and a member of the agency's Board of Directors to discuss the findings and recommendations made in the report. The Agency has upgraded its computer systems along with motion detectors to record better surveillance. The facility's Program Director will review the tapes and documentation log 2-3 times a week.

4. To avoid crises in high risk units, the facility's management should consider implementing floating crisis staff system with supervision to address unavoidable short term staff shortages.

The Agency has addressed staffing issues by instituting computer based calendars for shift assignment, increasing supervisory staff hours, implementing a rotating on-call system, adding leadership staff to the on-call list, adding part-time positions, and instituted 30 minute overlapping time schedules to cover unavoidable delays. The Agency has improved communication by using walkie-talkies with codes and mandatory response requirements.

5. It should be communicated to staff that they will not be disciplined for failure to restrain when the unit is short-staffed, and they have sent for assistance, consistent with the approved Restraint Training Manual.

Agency staff have been advised of this recommendation.

6. The facility's Procedures and Training should be amended to provide that whenever a client alleges an injury by staff or peers, the client should be seen by the nurse, who will document the presence of any injuries.

The Agency has added abuse allegation protocol to address this issue. In addition, the Agency recently received a $50,000 grant to add nursing support.

7. This report should be redacted and shared as a teaching tool for child protection regarding the importance of securing medical information and unit notes for the relevant time period, whenever a child is injured at a residential facility.

The Department agrees. The redacted report will be used for training of children protection staff.

GENERAL INVESTIGATION 9

ALLEGATION

A Department employee attempted to use her professional position to affect the decision of a police officer who had stopped her for suspicion of Driving Under the Influence (DUI).

INVESTIGATION

The employee was pulled over in her vehicle by the officer at 1:30 a.m. after failing to come to a complete stop at a traffic sign. The officer engaged the employee in conversation and, after administering two field sobriety tests, placed the employee under arrest for suspicion of DUI. In her official report, the officer noted the employee initially offered her Department identification rather than her driver's license, however the officer refused to accept it. The officer also reported that the employee mentioned two other local police officers by name and requested that they be contacted at that time. After being placed under arrest the employee again asked for the two officers to be contacted and explained she was familiar with them through her work for the Department. After the officer again refused, the employee said, "wait until you need my services," to her in a manner the officer perceived as a threat to not perform professional responsibilities if the two were to work together in the future.

In an interview with the OIG, the Department employee acknowledged having had, " a couple of drinks" on the evening in question. The employee denied attempting to use her position with the Department to influence the officer's decision and stated she had accidentally handed the officer her work ID because she had rearranged items in her wallet. The employee contended she had asked for the other two officers to be called so they could pick her up from the police station. The employee also stated the officer had misinterpreted her statement regarding needing her services in the future and that she had spoken out of frustration in response to verbal abuse by the officer.

In a separate interview with the OIG, the employee's supervisor stated the employee told her she had asked for the other officers to be called that night to serve as character references, although police had not asked or advised her to do so. A review of the police station log found the employee used her phone call to contact her father, who arranged for friends to pick her up, rather than either of the officers she had previously mentioned. An OIG review of tapes from the dashboard camera in the arresting officer's squad car showed no evidence the officer was verbally abusive or acted in an unprofessional manner. The employee was convicted of DUI and pled guilty to a traffic violation.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department employee should be disciplined for violating the principles of professional conduct.

Employee received a one day suspension.

2. The Department employee should not be assigned or given details of any investigation in which an officer or member of the local police department is the subject of the investigation.

The Department agrees, and has notified her supervisor.

GENERAL INVESTIGATION 10

ALLEGATION

A child protection investigator failed to terminate visits between an adoptive father and his 15 year-old daughter, who had alleged that he had sexually abused her, and did not notify the father of the allegations in a timely manner.

INVESTIGATION

The 15 year-old girl, whose mother was divorced from the father, alleged the abuse had begun when she was 8 and continued for a period of 5 years. The child protection investigator assigned to the case went to the family home and interviewed the girl and her mother as well as the girl's three other siblings her sisters age 10 and 7 and her 8 year-old brother. The children stated they felt safe in the mother's home, as the father no longer lived there, and the mother agreed the children would have no contact with the father. The OIG found no evidence to suggest any of the four children continued visits with the father after the investigation was opened or interacted with him in any way while it was pending. The investigator learned from the mother that the father had remarried and was currently living with four children between the ages of 17 and 6.

Since the family currently lived in a different county than where the alleged abuse had taken place, the Victim Sensitive Interview (VSI) of the girl was to occur in the county where the family previously resided. The investigator's supervisor requested that a parallel investigation be opened so that a local investigator could attend the VSI. Neither the primary nor the parallel investigator assessed the safety of the children currently living with the alleged perpetrator until three months after the sexual abuse allegations were made. In an interview with the OIG, the primary investigator's supervisor stated that staff from the parallel investigation would have been responsible for assessing the safety of the children currently living in the father's home and communicating with law enforcement in their area. There was no record in the case file of any requests or instructions from the primary supervisor to the parallel staff concerning the other children. In her interview with the OIG, the parallel investigator, who also assumed many of her supervisor's duties, stated she was not aware of any expectation for her to visit the father's current household and said she "knew very little about the family." Although the assorted child welfare professionals involved with this case frequently accessed the State Automated Child Welfare Information System (SACWIS) to obtain basic information, there was little direct contact between workers, particularly with regard to assignment of responsibilities. While Department Rules and Procedures do not currently address protocol for handling parallel investigations, the Department's Division of Child Protection has drafted a new set of procedures for future use.

Following further investigation, including additional allegations by the girl's seven year-old sister and the father's adult daughter that he had abused them, the report was indicated against the father. The OIG reviewed documentation from the case file showing a good faith effort to notify the father of the indicated report in a timely manner and noted his persistent refusal to cooperate with or contact the Department throughout the course of the investigation.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should immediately approve and disseminate the information transmittal regarding parallel investigations.

The protocol for parallel investigations was incorporated into revisions to Procedure 300, which is anticipated to be finalized in December 2008. The protocol for parallel investigations has also been discussed in monthly meetings with Child Protection management and staff.

2. In situations where there are abuse and neglect allegations in multiple households involving the same perpetrator and children in both households, the Department should consider a mechanism for opening an additional investigation rather than assigning that portion of the investigation as a parallel.

In response to the above recommendation and response, DCFS Office of Legal Services reviewed a Draft Information Transmittal outlining the process of Parallel Investigations. The Parallel Investigation process sufficiently covers situations when an investigation requires in person contact with the alleged child victim, a subject of the investigation, reporter, or other persons located outside the region/site/field (RSF) of the primary Investigation Specialist. The process also allows for information to flow efficiently between the primary Investigation Specialist and the parallel Investigator. No legal issues or concerns are present and the Parallel Investigation Process is satisfactory.

3. Because of staff shortages and the lack of written procedures addressing parallel investigations, the primary child protection investigator's supervisor should receive non-disciplinary counseling for failing to identify the need for the assessment of children alleged to be living in the perpetrator's home.

The supervisor was counseled.

4. Because of staff shortages and the lack of written procedures, the primary child protection investigator should receive non-disciplinary counseling for failing to assess the safety of the children alleged to be living in the perpetrator's home.

The investigator was counseled.

5. The Department should share this report as a teaching tool with the parallel investigator and other staff from the field office assigned to the parallel investigation.

The Regional Administrator and Child Protection Manager shared the report with staff.

GENERAL INVESTIGATION 11

ALLEGATION

Two people were not notified of indicated reports against them until after the time period to appeal the findings had expired.

INVESTIGATION

One case involved a teacher who did not learn a report of inflicting Cuts, Welts and Bruises to a student had been indicated against her until she contacted the OIG, one year after the case was closed. The second individual was never informed he had been indicated for Risk of Physical Injury/ Environment Injurious to his former girlfriend's two children three years earlier.

The OIG learned that in each case the individuals had changed residences while the reports were pending. The teacher had moved while the boyfriend had vacated the girlfriend's home as a condition of her safety plan and never returned to the household. In both instances notifications were sent to the address provided by the subjects at the inception of each investigation. While investigators in both cases were aware the subjects had relocated, the information was not provided to the State Central Register (SCR), which is responsible for disseminating official notices of indicated findings. It is crucial that the entity charged with performing this duty is provided with the most current information available to ensure timely notification and preserve subjects' right of appeal.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. When the subject of a child protection investigation either relocates during the course of the investigation or vacates the home as a condition of a safety plan, the child protection investigator shall procure the new address and inform the State Central Register of that current address prior to the closing of that investigation.

A Practice and Procedural Memo was distributed to child protection staff instructing investigators to note the new address in SACWIS.

GENERAL INVESTIGATION 12

ALLEGATION

A child protection investigator was under the influence of alcohol while conducting subject interviews in the family's home.

INVESTIGATION

The investigator was assigned to follow-up reported physical abuse of a 15 year-old boy by his mother. The investigator located the boy at his aunt's home, where he wished to stay rather than be returned to his mother. The investigator conducted interviews with the boy, his aunt and the mother after she arrived at the home. Eventually, an argument between the aunt and mother escalated into a physical altercation and the aunt summoned police to the home. After the investigator determined the boy would return home with his mother, the boy ran from the home. Ultimately the mother was indicated for two separate reports of abuse against the boy and he was placed with his maternal grandmother.

Accounts of the events that transpired in the aunt's home characterized the investigator's behavior as strange throughout; slurred speech, an unkempt appearance and the conspicuous consumption of a large amount of candy. In an interview with the OIG, one of the officers present described the investigator as being "unprofessional" and exhibiting "questionable behavior," though he could not say whether alcohol factored into her conduct. The investigator's supervisor told the OIG she had never had cause to suspect the investigator of being under the influence of alcohol during work hours. In her interview with the OIG, the investigator stated she had not consumed alcohol in over 20 years and that her persistent gum chewing and candy consumption was related to a recent effort to quit smoking. It was observed during the interview that while the investigator demonstrated an understanding and knowledge of the issues of the case, her casual speech and lackadaisical comportment could easily give the impression she was less than fully invested in the issue at hand.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator be disciplined for behaving unprofessionally during an investigation, including eating during interviews, and conduct that suggested she was not taking the family's concerns seriously.

The employee received an oral reprimand.

2. The child protection investigator should receive an Employee Assistance Referral to help her in dealing with not smoking in a manner that does not compromise the professionalism required in her job.

The Department agrees. The child protection investigator's supervisor will offer her an Employee Assistance Program.

GENERAL INVESTIGATION 13

ALLEGATION A Department employee misused his position and provided confidential information to a father in an effort to assist him in a custody dispute.

INVESTIGATION The father and his former girlfriend, the mother of their two year-old daughter, had been the subjects of three unfounded reports and minor police involvement regarding disputes over the custody and care of the girl. The girl, who had been diagnosed with Failure To Thrive (FTT), was in the custody of the mother and was receiving care through a hospital. The prior unfounded reports had dealt with issues of the girl's ongoing medical care. However, the mother was assessed to be appropriate with the child and compliant with directives for meeting her needs.

A social worker from the hospital where the girl was being treated received a call from the girl's father who demanded information regarding the hospital's involvement with the Department. In an interview with the OIG, the social worker stated the father related to her verbatim statements she had made during the prior child protection investigations. The social worker said she was "shocked" the father had access to such information and asked him who told him of her statements, to which he responded, "I have my sources." The next day the social worker was contacted by the Department employee who stated his professional status but characterized himself as a friend of the father who was concerned about the girl's care. The employee told the social worker he was concerned that neither she nor the girl's physician, whom he noted were both mandated reporters, had contacted the hotline to report her FTT diagnosis. The social worker informed the employee that she had not received consent to speak with him about the family and could not partake in any discussion. The employee then told the social worker he would obtain the consents. Four days later the father contacted the social worker and expressed his desire to allow her to discuss the girl's care with the employee, however the social worker refused his request. The social worker believed the Department employee had accessed the investigation and provided confidential information to the father.

In an interview with the OIG, the employee stated he had no direct relationship with the father but that the girl's paternal grandmother was his former supervisor and the employee made the inquiry in an effort to provide clarity. The employee said he told the social worker of his position with the Department only as a means to demonstrate a familiarity with FTT and that he was acting as an intermediary to obtain an explanation for the father as to why the doctor had not called the hotline. The employee stated he had only spoken to the father on the phone once, however when the OIG provided phone records showing his Department phone had been used to call the father's residence numerous times, he was unable to offer any explanation.

Four days before the father contacted the social worker, the State Central Register (SCR) received two calls ostensibly made by a police officer reporting the girl's FTT. As SCR contacts require a return call for verification, an SCR operator used the number provided by the caller to reach him. After the individual at the other end of the line answered with the name of the police officer, the SCR operator replied, "Ok. You are who you are so what do you need to know, sir?" The operator then read the contents of one of the prior unfounded reports to the person at the other end of the line. The operator did not follow procedures pertaining to verification of a caller authorized to receive confidential information as outlined in the SCR Call Floor Manual. Furthermore, the SCR manual expressly prohibits the dissemination of information contained in unfounded reports to anyone unless the report was deemed false or an instrument of harassment. The police officer who allegedly contacted SCR told the child protection investigator who followed-up with him that he had never contacted the Department about the case and was unaware of any other members of his department who had. SCR telephone records showed the call had originated from the residence the father shared with the paternal grandmother, which explained the father's access to confidential information without implicating the

Department employee. The doctor also received a call from an individual purporting to be a police officer and recorded part of the caller's phone number. The digits corresponded to the first part of the father's home telephone number. After the investigator learned of the fraudulent report to SCR by the caller purporting to be the officer she informed her supervisor; however, no further action was taken. An SCR administrator told the OIG there was no formal protocol for addressing false calls to the hotline. The OIG referred the case for criminal prosecution, but it was not accepted.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should administer non-disciplinary counseling for the Department employee for attempting to obtain a child's medical information without consent for release of information, and conducting phone calls regarding this case from his DCFS office.

The Supervisor counseled the employee.

2. The Department should consider counseling the SCR operator for failing to follow procedure regarding disclosure of information of an unfounded DCP report that was not classified as a harassment report. The operator failed to follow Rule 300 when he accepted a call for investigation of Failure to Thrive-81 from a reporter who was not a medical professional.

The employee was counseled.

3. This report should be shared with the State Central Register Administrator for training purposes and revision of the SCR Call Floor Manual, which is currently under review.

The report was shared with the SCR Administrator.

GENERAL INVESTIGATION 14

ALLEGATION

A Department administrator used the state email system to forward political messages to Department employees.

INVESTIGATION

In one instance, the Department administrator forwarded a message he received at his personal email address from a congressman endorsing candidates in an upcoming election. The administrator sent the message to five Department employees or contractors at the email addresses assigned to them by the Department. One of the Department contractors served in a position directly subordinate to the administrator. On two other occasions the administrator forwarded political messages he had received directly to his Department email address. The State Officials and Employees Ethics Act prohibits soliciting votes or preparing or distributing materials on behalf of a candidate or political organization. In an interview with the OIG, the administrator acknowledged having signed documents confirming his knowledge and understanding of Department Procedure regarding the use of the state email system, which is limited to official government business.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department Administrator should give written notice to the Office of the Congressman who contacted him to cease sending campaign, political or fundraising literature to him at his state email address.

The Department Administrator transferred to another state agency prior to implementing this recommendation.

2. The Department should discipline the administrator for using the state email system for political purposes.

The Administrator received non-disciplinary counseling.

OIG Response: The recommendation was for discipline and the OIG maintains that the Administrator's improper use of email should be reflected in his personnel file.

GENERAL INVESTIGATION 15

ALLEGATION

A Department caseworker posted confidential information regarding active clients on her world wide web log (blog).

INVESTIGATION

Concern regarding content on the blog arose after information was posted suggesting an individual who had recently been convicted of predatory criminal sexual assault had committed previous illegal acts that had not been prosecuted. The blog's author presented herself as having firsthand knowledge of the individual's history as a result of her work in the Department field office where the case originated. The author stated she had been directly involved with children the individual had previously victimized and offered reasons why those cases were not prosecuted.

Although the blog's author used a pseudonym, the author's picture accompanying the post was identified as a Department caseworker. In an interview with the OIG, the caseworker acknowledged being the author of the blog but denied having any personal knowledge of other children being victimized by the individual. The caseworker stated she had compiled the information regarding previous victims from other news sources and transformed the account into a personal narrative to make the story more interesting. The OIG was unable to locate any of the news sources the caseworker claimed to have utilized nor could she produce the information herself. Although the caseworker did not explicity identify herself on the blog as a Department employee, the information contained in the post suggested she was. As such, a reasonable person who accepted the information as fact could conclude that the Department failed to provide all pertinent information to the State's Attorney's Office in its prosecution of a case involving predatory criminal sexual assault. The caseworker stated none of her co-workers had ever discussed the blog with her and she did not believe other Department employees were aware of its existence. The OIG determined that while the caseworker had not violated confidentiality she had posted inaccurate information on her blog that portrayed the Department in a negative light.

The OIG attempted to conduct a review of Department internet traffic in order to determine whether Department employees had accessed the blog. However the software acquired by the Department to conduct such searches proved to be prone to inaccuracies, making any findings unreliable.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department caseworker should be disciplined for violation of the Department's Code of Professional Conduct.

The Department caseworker received a written reprimand.

2. The Department should secure more reliable software to use when reviewing use of internet web sites.

The Department agrees. The software was purchased and installed.

GENERAL INVESTIGATION 16

ALLEGATION

Three foster children resided in an unlicensed home with an unapproved, 21 year-old caretaker while their foster mother maintained a separate residence.

INVESTIGATION

The three male children with special needs, ages 17, 16 and 14, had independently been placed in the foster mother's care. The two older boys had each lived with the foster mother for over two years while the youngest had only been in the household for six weeks. Two days after the third boy was placed in the home, the foster mother relocated the family to another residence in an apartment complex because of needed repair work being conducted at her home. The foster mother left the boys at the apartment in the care of her 21 year-old male cousin and resumed living at her home. The children's situation came to light after the 14 year-old was hospitalized and told his Guardian *ad Litem* of the living arrangement. The boy stated the foster mother did not want the children to live in her home and told them, "it would be good for [the boys] to be independent."

The foster mother contended the private agency responsible for administering her license was aware the family would be "temporarily" moving to the apartment while their home underwent repairs. Although the foster mother had made her relocation plans known to the private agency, she had never informed staff when the move actually occurred, as required, and did not suggest she would not be living in the apartment with the children. The foster mother cancelled an appointment with the private agency licensing worker scheduled in anticipation of the move because she said the family had not yet relocated. Records from the apartment complex management company showed residents began registering complaints about noise in the previously vacant apartment two weeks earlier. There was no evidence to suggest the foster mother ever resided at the apartment or maintained any authority over the boys' actions while they were there. On three evenings within the first few weeks the boys were in the apartment, police responded to disturbance complaints at the address. On each occasion the 21 year-old presented himself as the head of household and the foster mother was not present at any time.

In an interview with the OIG, the caseworker, who had visited the apartment and met with the boys as well as the 21 year-old cousin, said she assumed the young adult was the foster mother's boyfriend but did not introduce herself or ask for the cousin's identity. Although the case notes described the location of the foster mother's bedroom, the caseworker stated she never observed the room or asked the boys if she in fact lived with them in the apartment. The caseworker did not inform the licensing worker of the family's move until two weeks after visiting the apartment. Upon learning of the move, the licensing worker scheduled another meeting with the family at the new residence. However on the agreed upon date the foster mother again cancelled. One week later the licensing worker conducted an emergency assessment of the family's original home and found it to be in satisfactory condition. A decision was made to reduce the foster mother's licensing capacity to two and the youngest boy was moved to another placement while the two older boys remained in the foster mother's care.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency should meet with the caseworker to discuss issues of introducing oneself to adults and ascertaining their identity prior to visits with children. The private agency should also have discussions around creating a partnership between casework and licensing to ensure better communication of critical information and more proactive monitoring.

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

to discuss the issue of ascertaining the identity of the adults in the home. The agency also reviewed and revised its Home Visit Policy to better reflect the Agency's practices and re-educated its foster care caseworkers to establish or confirm the identity of all adults in the household during each visit. The Agency revised its policies to require monthly interdisciplinary case staffings to ensure continued coordination of services.

2. The private agency should discuss this case with the licensing worker to explore more proactive responses after the second time the foster mother cancelled a scheduled licensing visit.

The Agency agreed with this recommendation. Agency management discussed the report with the licensing worker. The Foster Care Division Manager revised the Home Visit Policy to include supervisory intervention after the first unsuccessful unannounced visit and the Agency provided training to its employees on the revised policy.

3. The facts of this investigation concerning the foster mother should be shared with the Guardian *ad litem* to enable them to make a fully informed best interests decision regarding the placement of the older two boys.

The Department agrees. The OIG shared a redacted report with the Office of the Public Guardian. The teenage boys were moved to a new foster home. Subsequent to the move to the new foster home, one of the boys moved into an independent living placement.

4. This report should be shared with the Department's Central Office of Licensing to determine whether the foster mother should be cited for licensing violations concerning her failure to notify the private agency of the move, her failure to notify the private agency of her cousin's caretaking role and her misrepresentation to the licensing worker that the family had not yet moved when she cancelled their first meeting.

The report has been shared with the Central Office of Licensing and the foster home has been placed on hold.

GENERAL INVESTIGATION 17

ALLEGATION	A child protection investigator engaged in inappropriate contact with an 11 year-old girl on an internet social networking site.

INVESTIGATION

The girl, whose family was involved with the Department, had created a profile page on a social networking site. On the page, the girl listed her age as 14 and provided a picture of her mother holding the girl's infant brother. The girl received a message from someone identifying himself as a Department employee in the area and discussed his children and their ages. When the girl got the message she showed it to her caseworker, who knew an investigator in her office with the same name and same aged children.

In his interview with the OIG, the investigator stated he had utilized the social networking site as a means of meeting prospective dates and had composed the message as a "form letter" he sent to women whose profiles he found interesting. The investigator estimated he sent out between 20 and 50 communications each week and corresponded with those who replied. The investigator stated that while he usually based his interest on the content of the women's profile pages, he sometimes contacted them based solely on the pictures they provided. In this case, the picture included in the profile was of a woman, not a child. The investigator insisted he had no intention of contacting a minor and had deleted his own profile page in light of his recent engagement.

The OIG found the investigator to be forthright and credible and identified no evidence to suggest he willfully sought to engage in communication with a minor female, however it was imprudent to distribute mass mailings of a message in which he identified himself as a Department employee. The OIG learned of another instance in which the investigator began corresponding with a woman through the networking site who turned out to be a Department client. Although the investigator discontinued contact with the woman after learning of her status he did not report the situation to his supervisor, as required.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child protection investigator should receive non-disciplinary counseling for failing to inform his supervisor of his virtual encounter with a Department client.

The investigator was counseled.

GENERAL INVESTIGATION 18

ALLEGATION

A Department attorney attempted to influence the outcome of a pending child protection investigation.

INVESTIGATION

A child protection investigation stemmed from a car accident in another state that killed three members of a family, two of them children. The children's father, the driver, tested positive for marijuana and cocaine after the accident and acknowledged having fallen asleep while driving. The child protection investigator assigned to the case reached a preliminary decision to unfound the report based on a doctor's uncertainty whether the drugs present in the father's system caused impairment, however she was instructed to continue working on the case by the child protection manager.

While the report was still pending, a Department attorney contacted a child protection administrator. In an interview with the OIG, the child protection manager stated the Department attorney possessed knowledge of the investigation he could have obtained only by accessing the State Automated Child Welfare Information System (SACWIS). The attorney inquired as to why the report was being unfounded and expressed his belief the decision was incorrect. The administrator instructed the child protection manager to respond to the attorney. In her interview with the OIG, the child protection manager said the attorney informed her he had been in contact with a private agency therapist who was familiar with the family and had personal knowledge of issues in the home. The attorney told the manager that both he and the therapist were personal friends with the children's maternal grandparents and had taken an interest in the family's welfare following the accident.

In his interview with the OIG, the Department attorney acknowledged using the SACWIS system to obtain information about the pending report, however he stated he had only accessed the database in order to learn the name of the assigned investigator. The attorney said he contacted the administrator as a "concerned mandated reporter" in order to provide additional information he believed was vital to developing a complete portrait of the family. The attorney told the OIG he was attempting to relay information provided to him by the private agency therapist, who had attempted to contact the State Central Register (SCR) directly without success. In a separate interview with the OIG, the therapist denied ever making his own attempt to contact SCR and stated he had only a personal relationship with the family and was not involved with them in any professional capacity. A review of the Department attorney's personnel file found he had been trained on authorized use of the SACWIS system and had signed a certificate of understanding prohibiting use of SACWIS for personal reasons.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department attorney should be disciplined for accessing SACWIS regarding a personal matter. The attorney should receive non-disciplinary counseling for expressing his opinion on a personal matter regarding the outcome of a pending child protection investigation.

The attorney received non-disciplinary counseling.

GENERAL INVESTIGATION 19

ALLEGATION

A former Department supervisor and her husband, a current Department employee, interfered with the foster placement of a 15 year-old girl.

INVESTIGATION

The girl had been removed from the home of her adoptive father when she was 12, after she revealed he had been sexually abusing her since her adoptive mother's death three years earlier. After being taken into Department custody, the girl exhibited numerous behavioral problems, including suicidal ideation and at least one attempt, and moved through multiple specialized foster homes and residential facilities. Over time she developed a rapport with the Department supervisor overseeing the handling of her case. The supervisor was utilized as a source of support for the girl as she had significant trust issues and was particularly suspect of men. After the girl was placed in a residential facility, the supervisor accepted a position at the same facility. The girl was informed by staff that the nature of her relationship with the supervisor would have to change but that she could keep the supervisor's cell phone number and contact her directly when she felt she was in crisis. Two months after the supervisor resigned her position at the facility, the girl was placed in a traditional foster home.

Following her placement in the home, the girl contacted the supervisor who then introduced herself to the foster mother and offered to serve as an informal support resource. The girl began spending a substantial amount of time with the supervisor and her husband, including alternate weekends and extended periods around holidays. Through their conversations with the girl, the couple determined her placement with the foster mother was "not a good fit," and endeavored to become licensed as foster parents with the goal of having the girl placed with them. The supervisor and her husband did not inform the foster mother of their intention to assume custody of the girl nor did they make the girl's current caseworker aware of the significant role they played in her life. After the caseworker learned from the foster mother of the couple's presence in the girl's life, she took no action to formalize their visits or ensure the boundaries of the foster parent/child relationship were respected.

The foster mother had grown frustrated with what she perceived as the couple's interference with the placement and complained to the caseworker about them attempting to pick the girl up from school or transport her from the home in the foster mother's absence. After the girl ran away from her placement, the foster mother accused the couple of withholding the girl's whereabouts and filed a missing persons report. The following day the couple reported the girl had called them and the supervisor's husband took the girl to the Guardian's office. The Guardian then instructed the husband to transport the girl to an Emergency Reception Center (ERC). Having been made aware of complaints made against them by the foster mother, the couple provided a document to the Guardian's office offering their response to the allegations of inappropriate interaction with the girl. Ten weeks later the supervisor and her husband were licensed as foster parents and the girl was placed in their home.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The private agency handling the foster parent licensing should ensure that when a license application is made for placement of a specific ward, the licensing worker informs the ward's assigned caseworker about the application.

The Office of the Inspector General shared a redacted copy of the report with the private agency. The private agency agreed with the recommendation. The private agency holds weekly meetings to discuss licensing and placement activity. Private agency program managers will use aspects of this case as a teaching tool with their teams to ensure checks and balances of protocols.

2. The private agency caseworker should be reprimanded for non-compliance with the visiting requirements outlined in Department Procedures 315.110.

The caseworker and supervisor are no longer employees of the private agency.

3. The Advocacy Office for Children and Families should review the handling of the foster mother's complaint to ensure there was "a final report to the person initiating contact regarding the resolution," as outlined in Administrative Procedure 21, and to determine the advisability of sending a complaint directly to an employee when the complaint contains issues which might more appropriately be investigated by the Office of the Inspector General.

The Department agrees. The Advocacy Office for Children and Families (AOCF) Administrator reviewed the Advocate's handling of the complaint and the Advocate did make contact with the caller. However, the phone contact note did not reflect exactly what was said. The Administrator reiterated to the Advocate the need to be specific with contact notes.

All Advocacy Office staff were reminded in a staff meeting on September 27, 2007, of the requirements for follow-up phone calls to callers and staff were again reminded on July 24, 2008, of the same, via email.

The AOCF Administrator clarified with staff that the employee whom the complaint is about should not be included in an email to outside supervisor(s) and to contact supervisory staff in AOCF if in doubt. The Administrator of AOCF asked each Advocate to indicate, by reply email, that they have read email and understood the recommendations and staff have done so.

4. The supervisor's husband, a current DCFS employee, should receive non-disciplinary counseling on Rules 437, specifically for failing to advise his supervisor of becoming a resource for the ward and seeking licensure toward her adoption. [section 437.70, "Prohibition of Employee Conflicts in the Care of Children."]

The employee received non-disciplinary counseling.

GENERAL INVESTIGATION 20

ALLEGATION

A child protection investigator made sexual advances toward the mother of a family that was the subject of his investigation.

INVESTIGATION

The investigator was assigned to the case after allegations of risk of harm were made against the mother of four children, aged two to eleven, and her boyfriend. The investigator conducted all necessary interviews and recorded his contacts with family members. He also consulted with the children's school and local law enforcement and found no history of concerns or complaints. Having found no evidence the mother and her boyfriend had placed the children at risk or were unable to serve as adequate caretakers, the investigator and his supervisor determined to unfound the report.

Following this decision, the investigator called the boyfriend to inform him the report had been unfounded. The investigator inquired as to the mother's whereabouts and stated he needed to see her in order to ensure the children were in a safe environment. The boyfriend told the investigator the family had temporarily relocated to a motel and provided him with the address. The investigator then went to the motel and met with the mother alone in the family's room. In an interview with the OIG, the mother stated the investigator sat on the bed next to her, despite the availability of other seating in the room, and began touching her on the leg and inner thigh. The mother said the investigator at one point attempted to kiss her and brought up the boyfriend's criminal history while questioning why she was in a relationship with him. The mother said she paced the room in an effort to avoid the investigator's repeated physical contact and described his behavior as, "sick and not appropriate at all." The encounter ended when the boyfriend arrived outside the motel after picking the children up from school. The mother told the boyfriend of the investigator's behavior after his departure and the couple reported the incident to the Department a few days later.

In his interview with the OIG, the investigator denied making sexual advances towards the mother during the meeting in the motel room. The investigator acknowledged he sat on the bed next to the mother but did not consider that to be inappropriate. He was unable to explain why his case notes showed he had spoken to both the mother and the boyfriend on the phone when he called the boyfriend to ask about the mother's whereabouts or why he had not documented the visit to the motel. The investigator insisted he had been instructed by his supervisor to meet with the mother, however the supervisor told the OIG there would be no reason for him to do so since the report had been unfounded and closed. The supervisor said that if she had asked him to conduct the visit she would have documented the request.

Prior to the OIG investigation, the investigator requested and received a transfer to another state government agency. The OIG made a referral to the Child Welfare Board for revocation of the investigator's child welfare license.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should issue a "no re-hire" letter to be placed in the child protection investigator's personnel file.

The investigator transferred to another state agency prior to being disciplined. The Office of Legal Services referred to the Office of the Executive Inspector General the issues of whether the Department can issue a "no re-hire" notation for his personnel file and whether Central Management Services can proceed with discipline despite the transfer.

GENERAL INVESTIGATION 21

ALLEGATION	A Department employee operated a private business during work hours and utilized state resources for personal use.
INVESTIGATION	The employee had displayed four business cards on her desk in her Department office with her name on them promoting businesses related to travel and mortgages. An OIG review of the employee's usage of the state internet system showed that on multiple occasions she had sent or received emails related to travel arrangements, however there was no indication she had used her Department phone for work unrelated to the Department. In an interview with the OIG, the employee stated she was not involved in a business endeavor but a "travel club" for which she did not receive monetary gain. The employee said she benefited from her relationship with the club by receiving discounted or free vacations by recruiting others to purchase trips through certain providers. The employee denied that any money changed hands during work hours or that she pressured co-workers to participate in the group. The employee acknowledged she had previously signed the Department Certificate of Understanding regarding use of the state email system and that her actions were in violation of Department Procedure.
OIG RECOMMENDATIONS / DEPARTMENT RESPONSES	**1. The employee should be counseled for violation of Department Administrative Procedures.** The employee was counseled.

GENERAL INVESTIGATION 22

ALLEGATION

An administrative case reviewer suggested that the mother of two children who had been removed from her custody be neutered as a provision of her service plan.

INVESTIGATION

The mother's two youngest children had been removed from her custody and placed in relative foster care as a result of persistent issues of substance abuse and domestic violence. During an Administrative Case Review (ACR) convened to establish objectives for the mother's service plan, the reviewer stated the mother made poor choices in selecting romantic partners and commented that perhaps she should be neutered. In separate interviews with the OIG, the mother's attorney and her caseworker, who were both present at the ACR, asserted the reviewer had made the statement to have the mother neutered. The mother's attorney said the mother told her afterwards that the reviewer's comments made her feel like a dog because, "dogs get neutered, not people." The attorney also stated the reviewer told her he was unaccustomed to working with a lawyer such as herself but rather, "attorneys that are actually concerned about what is best for children."

In his interview with the OIG, the reviewer denied suggesting the mother be neutered, though he acknowledged criticizing her ability to choose appropriate romantic partners. The reviewer stated the mother's relationships had been identified by the caseworker as a central issue and he believed her pattern of behavior represented the primary obstacle to the children being returned to her. The reviewer could not explain why all of those present at the meeting claimed to have heard him make the comments about having the mother neutered and said he had recently spoken with the caseworker to discuss safety issues of the case.

The OIG again contacted the caseworker who confirmed she had spoken to the reviewer since her previous interview with the OIG. The caseworker stated the reviewer did not call her about the case but to discuss the OIG investigation. The caseworker said the reviewer told her the conversation about neutering was, "meant as a joke," and reiterated the reviewer had made those comments during the ACR in the mother's presence.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Administrative Case Reviewer should be disciplined for his unprofessional conduct during the ACR.

The Administrative Case Reviewer was suspended for three days without pay.

Note: The Director requested DCFS Office of Legal Services to issue a memo to ACR Reviewers and Administrative Law Judges with general instructions to cease issuing personal opinions.

A Professional Conduct Memo was sent to Deputies with employees with specified titles on November 3, 2008 for distribution.

GENERAL INVESTIGATION 23

ALLEGATION

Following a clinical review, the Administrative Case Reviewer suggested to the attorney representing one of the parties that their client may have received unfavorable treatment from a private agency because of the client's race.

INVESTIGATION

The case involved the foster parents of three siblings, ages five, four and two years old, who had continued residing in the same home while initiating divorce proceedings. Following a physical altercation between the couple that was witnessed by the children, the foster father obtained an emergency order of protection against the foster mother for himself, the three siblings and the couple's biological daughter. Local police contacted the private agency handling the family's case and informed personnel of their intention to serve the order of protection, which would require the children to be removed from the home. The private agency complied and placed the siblings in an alternate placement.

The foster mother appealed the decision to remove the children. The private agency opposed returning the children to the foster mother, and the foster father had already expressed his unwillingness to care for the children on his own. The foster mother was initially unsuccessful in appealing the private agency's decision. After the order of protection was vacated, it was determined a second hearing would be held following an assessment of the foster mother's parenting ability. While awaiting the assessment, the foster mother was only allowed contact with the children during two supervised visits. During a follow-up phone call with the Administrative Case Reviewer after the foster mother's second appeal was unsuccessful, her attorney asked why the private agency's recommendations had been consistent with the foster father's position. The Administrative Case Reviewer responded, "[The foster father] is white," in reference to his ethnicity, which is different from the foster mother's. The Administrative Case Reviewer's statement prompted the foster mother's attorney to file a race discrimination complaint against the private agency with the Office of Civil Rights of the Department of Health and Human Services.

In an interview with the OIG, the Administrative Case Reviewer said he was "thinking out loud,' when he made the statement to the attorney and characterized the remark as a question rather than an assertion. The Administrative Case Reviewer said he had no evidence or knowledge that the private agency was biased against the mother and realized later he had made an imprudent statement.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Administrative Case Reviewer should be disciplined for leveling an irresponsible charge against an agency without evidence.

The Department has begun disciplinary proceedings.

GENERAL INVESTIGATION 24

ALLEGATION During the course of conducting a separate investigation, the OIG identified potential misfeasance that led to a review of Department contracts with a mentoring and counseling agency, the source of the agency's program plans, the performance and monitoring of the agency's subcontractors, as well as the adequacy of program monitoring and outcomes by the DCFS Office of Contracts and Grants. The OIG also reviewed agency documentation that suggested two of the agency's subcontractors billed for counseling services they did not provide.

INVESTIGATION The OIG reviewed contracts between the agency and the Department, agency program plans, personnel and counseling files, employee time sheets and billing vouchers and bank statements.

The OIG determined that the agency failed to provide timely quarterly financial reports to the Department. Provision of quarterly reports and a review of those reports by the DCFS Office of Contracts and Grants would ensure that the Department's funds were being used properly and that the agency was meeting the program goals established in the contract and program plan. Incomplete financial reports submitted to the Department after the initiation of the OIG investigation revealed that the agency did not have a cost allocation system, that Department funds were being used to support non-DCFS programs, and that contract funds were being allocated for administrative costs beyond the amount allowed by the contract.

A review of the agency's mentoring program plan revealed that the plan appeared to have been substantially copied from a program plan submitted by another agency without the approval of that agency. Interviews with the DCFS contract monitor revealed that she was instructed to use the program plan as a prototype. In effect, the OIG determined that DCFS essentially "lifted" the program plan and inserted it into the agency's contract. There was no attempt by the Department's Office of Contracts and Grants to ensure that the agency had the resources and ability to fulfill the conditions of the program plan in the contract.

Although some of the families referred to the agency's counseling services required intensive therapeutic services, some of these families received counseling from Bachelor level counselors with no supervision while other families received counseling from Master's level counselors, none of whom had clinical licenses or were being supervised. The DCFS contract with the agency required clinical licensure or supervision. Agency administrator's made the decision to designate the counselors and mentors as independent contractors rather than as employees, since the agency could not afford to offer employee benefits, such as health care. The agency did not provide supervision to its mentoring and counseling employees.

A review of agency billing statements and counselor time sheets revealed that two of the agency's counselors submitted timesheets and billing vouchers for services they did not perform or for services performed during hours in which they were full time employees of and being paid by another child welfare agency. In some instances, the OIG's review of billing records revealed that the agency director failed to confirm the accuracy of counseling reports from the counselors. In some instances, time sheets were submitted claiming to see two families at the same time. Agency administrators failed to diligently ensure that the timesheets and service delivery documentation submitted by their counseling and mentoring staff were accurate.

An OIG review of DCFS Contracts and Grants oversight of this agency and its contracts with the Department indicate that the Department approved funding for an agency which, at the time of funding, had less than $100 in the bank. An interview with the DCFS contract monitor revealed that there was no expectation that DCFS would review the budget submitted by the agency or assure that appropriate fiscal safeguards were in place for new agencies. DCFS Contracts and Grants had no mechanism in place to ensure that the agency was meeting performance outcomes for the program as a whole as well as for individual clients.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should terminate its contracts with the mentoring and counseling agency.

The Department has ceased contracting with the agency.

2. The Department should conduct an audit of the mentoring and counseling agency. The required 13 month reconciliation report should be critically reviewed to determine whether there are disallowable administrative costs and whether there is an adequate cost allocation system.

Agencies are required to submit annual audits 180 days after the end of the fiscal year, barring a request for an extension. Audits are reviewed upon receipt.

OIG Response: The response does not address whether the reconciliation report was received or reviewed as required, and whether disallowable costs were identified.

3. Contracts and Grants must be retrained to ensure critical review of budgets and quarterly reports of both grantees and contractors.

The Department agrees. Training is scheduled for March 2009.

4. The Office of Contract Administration should assure that contracted agencies submit program plans that meet the service needs of the DCFS client population and that the contracting agency has the resources and ability to meet those needs.

The Department agrees. The Department has begun the review of FY10 program plans.

5. The Office of Contract Administration should require quarterly reports from mentoring and counseling agencies on progress toward achievement of program plan goals, both in relationship to individual clients and, in the aggregate, for all clients served under the contract.

The Department agrees. The revised requirements will be included in the FY10 contracts.

6. The Department should not allow counseling services to be provided by bachelor level professionals with no supervision.

The Department requires a minimum of a master's degree for professionals providing counseling services. Those agencies that may have been grandfathered in to allow a bachelor's level professional to provide counseling will be reviewed on a more frequent basis to ensure that adequate supervision is provided.

OIG Response: This was not a grandfathered agency. This agency's Executive Director had a master's degree. However, those providing services, for the most part, only had bachelor's degrees and were not provided supervision.

7. The Department's Resource Referral Form should be modified to include the service category "therapeutic counseling services."

The Department agrees. The Resource Referral Form is being revised.

8. The Department must implement security safeguards prior to enabling remote access to SACWIS on

personal computers. Office of Information Technology Services (OITS) must obtain direct approval from the private agency's executive director prior to enabling remote access for private agency employees. Two documents should be developed in connection with remote access: (1) The agency director should sign a form agreeing to notify OITS within 24 hours of the employee's change in status or departure from the agency, and (2) The employee should sign a document specifically acknowledging the confidential nature of the remote access application and agree to ensure that outside persons do not have access to the application. The employee should be informed and agree to the requirement that, in order to maintain confidentiality, the Department prohibits transferring or downloading any confidential information onto their personal computer or email. The OITS should maintain and routinely update a database of remote access to SACWIS users.

The Director and the Office of Legal Services are reviewing this recommendation.

9. The private agency should consider discipline, up to and including discharge, for the caseworker who provided counseling services for the mentoring and counseling agency during her regularly scheduled work hours as a full-time employee of the private agency.

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

GENERAL INVESTIGATION 25

ALLEGATION

The State Purchasing Officer identified several irregularities in the Fiscal Year 2006 and Fiscal Year 2007 contracts between the Department and a data bank technology company.

INVESTIGATION

The Department began contracting with the technology company in 2001 for assistance in conducting Diligent Searches for missing parents. In fiscal year 2007, the contract was amended, and additional funds were provided, for the technology company to perform additional administrative searches, known as Level V Administrative Search. These searches were to be performed by a particular individual, who described his work as: "to investigate the sexual exploitation of children" and "to develop criminal cases against perpetrators . . . ." The State Purchasing Officer was concerned because the work appeared beyond the scope of the contract and some of the work appeared beyond the scope of the Department's authority. The State Purchasing Officer was reviewing the contract in connection with an open Request for Proposal [RFP] where competing companies asked for clarification regarding the Level V Administrative Search option.

The Level V Administrative Search option was an outgrowth of the Department's need to investigate sexual abuse charges against religious figures which were first made after the victim reached adulthood. The Department had entered into an agreement with the Archdiocese of Chicago to investigate allegations against priests where the abuse may have occurred many years earlier than reported. By statute, the hotline can only accept calls when a victim is a minor. When adult victims of childhood abuse come forward, it is necessary to review the case to determine whether there are existing victims who are still minors. Usually, this question turns on whether the alleged perpetrator has current access to children. Because the use of databases could be helpful in determining current access to children, the Department provided additional funds to the technology company's contract to allow it to assist the Department in preliminary investigations of accusations of sexual abuse or exploitation where the reporter was abused as a child, but was now an adult. The terms of the contract were not amended, but the technology company was asked to use the additional funds to hire a specific individual who would have access to their databases.

In addition, in order to access the technology company databases, the Department arranged for the individual to have access to the New Hire database, maintained by the Illinois Department of Employment Security. The database tracks all new hires in the state and while information is confidential, an exception is permitted for the Department of Children and Family Services to help in finding missing parents.

When interviewed by the OIG, the individual hired by the technology company explained that the bulk of his work was not associated with hotline calls. Instead, he performed research on the 55 clergy that the church had publicly identified as "substantiated" cases of child sexual abuse or exploitation to determine whether they had access to children. He also investigated any new allegations by adult victims. The individual however, repeatedly described his work in terms of building criminal cases against the alleged perpetrators. Contrary to the legislative mandate of the Department to receive allegations and investigate them within a limited period of time, the Level V Administrative searches were unending. The Department Administrator who facilitated the addition to the contract was no longer employed by the Department. During the investigation, the OIG informed the Department of the facts and the Department determined to cancel a pending Request for Proposal and ensure that the individual was no longer employed to perform Level V Administrative searches.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should carefully review the new Request for Proposal (RFP). If the number of non-administrative level V monthly searches is only around 600 (estimated 1000 less the

estimated Administrative Searches), the current contract compensation appears high.

The new Diligent Search RFP was cancelled and Level V Administrative Searches through the current vendor were terminated. A new RFP was issued at a lower amount with a lower estimate of searches.

2. The Department should pursue the ongoing use of the IDES New Hire database to identify absent fathers, in line with its intended purpose. The new RFP should be adjusted to provide for staff to go to IDES to manually perform the searches.

As a result of the interim corrective actions which terminated Level V Administrative Searches, the necessity of IDES access has been eliminated.

3. The Department and the church officials should review and clarify the Joint Protocol, to specify under what conditions, if any, the church officials should contact the Hotline when the alleged victim is no longer a minor.

The Department agrees. The implementation of this recommendation is in progress.

4. The Department should consider amending the Risk of Sexual Injury Allegation to include situations in which prior sexual abuse of a minor is confirmed through investigation and the perpetrator of the prior abuse has current access to child/ren.

The Safety workgroup is reviewing this recommendation.

GENERAL INVESTIGATION 26

ALLEGATION

A Department employee attempted to send a co-worker's work-related emails to his own personal account.

INVESTIGATION

A Department employee gained access to a co-worker's computer while helping her attempt to resolve a technical problem. The co-worker left her station to go to lunch and upon her return found an error message on her screen showing that a message had been unsuccessfully sent to a private email address that contained the employee's last name. The undeliverable message contained all of the co-worker's emails to date. The worker stated she had not authorized anyone to work on her computer in her absence and had not shared her user name or password with fellow employees. The worker's computer was directly next to the work station manned by the Department employee who had assisted her earlier in the day. The employee was recognized in the office as being computer-literate and was frequently enlisted by others to help resolve issues.

Throughout his interview with the OIG, the Department employee was evasive and made deliberate attempts to stifle meaningful communication. He stated at the outset that he did not know his job title, where his work station was located or his Department email address. When asked if he recognized the personal email address where the co-worker's emails were to be sent, the employee initially denied any knowledge of the address. After conceding he often answered to a nickname that was part of the address, the employee acknowledged it as an "old" mailbox before finally admitting it was his current personal email address. The employee offered numerous implausible explanations as to how an effort could be made to send all of the co-worker's emails to his personal inbox from her computer without his knowledge. The employee contended he frequently sent policy transmittals from work to his personal email in order to maintain copies that would otherwise be deleted by the Department system because of capacity constraints. The Department's Office of Information Technology Services informed the OIG that the capacity of the automatic archive system is effectively limitless, meaning there is no risk of old emails being deleted.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department employee should be disciplined for failing to cooperate with the Office of the Inspector General and for attempting to transmit another employee's emails to his personal email account.

The employee was suspended for five days.

2. The Department employee should not be allowed to assist other employees with computer problems.

The Department agrees.

GENERAL INVESTIGATION 27

ALLEGATION

A Department contractual employee served on a team evaluating bids for a Department contract. One of the bidders was a private agency where the contractual employee had previously worked.

INVESTIGATION

The contractual employee worked for the Department through an agreement with an educational institution. Through her involvement with the Department, the employee was selected for inclusion on the team evaluating bids from private agencies to provide relative foster parent services to Department clients. Although the employee had previously worked for one of the bidding agencies she did not disclose her past involvement with the agency prior to accepting the position and did not recuse herself from the decision making process after the agency submitted its bid.

In an interview with the OIG, the employee acknowledged having worked for the agency nine years earlier for a period of less than a year. The employee stated she had worked without a supervisor during her time with the agency. However, her personnel file with the educational institution listed a "previous supervisor" from the agency as one of the employee's references. The employee stated she did not view her history with the agency as a potential conflict of interest because her current role was unrelated to her previous work. She also expressed her belief that since "DCFS is a small department," many professionals in the field would have worked for the Department or other agencies at some point in their careers. She also stated she identified a conflict of interest as being "more egregious" than her situation. The employee acknowledged having completed ethics training as a prerequisite of her hiring by the educational institution. The employee was unaware the institution also contracted with the private agency until being informed by the OIG. The employee stated she was told she did not have to participate in the Department's ethics training since she is a contractual worker.

While the OIG found no evidence to suggest the employee attempted to improperly steer the evaluation team in any way, the importance of avoiding perceived conflicts of interest is vital to ensuring public confidence in the Department. Decisions made by the Department must appear to be transparent and devoid of undue influence to instill confidence in those the Department wishes to serve.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The contractual employee should receive retraining in ethics issues, particularly conflicts of interest, through the educational institution.

The contractual employee completed a Conflict of Interest Exam developed by her employer.

2. At a meeting between the Office of the Inspector General and the Director's Office in January, 2008, the Director agreed that the Department would revisit the issue of requiring private agencies to have a Code of Ethics at least as stringent as the Department's. The Director indicated that the Department's Chief of Staff would draft boiler plate language for private agency contracts for the inclusion of a code of ethics as least as stringent as the Code of Ethics which binds Department employees. The OIG reiterates its recommendation that private agency contracts should contain a provision requiring private agencies to have an Ethics Code at least as stringent as the Department's Code of Ethics for Child Welfare Professionals.

DCFS Office of Legal Services is working with the Chief of Staff to determine the best method of dissemination of the reminder.

GENERAL INVESTIGATION 28

ALLEGATION

The Department was unable to locate the birth certificate of a 17 year-old girl, who had been a ward for three years, in advance of her pending adoption.

INVESTIGATION

The girl, who was severely autistic and demonstrated significant developmental delays, had been born in another country and had been adopted when she was two through a private arrangement after being abandoned by her biological parents. The girl's adoptive mother died when she was 11, however her father continued to care for the child independently. Two years later the girl was taken into protective custody after the father stated that his worsening financial, mental health and substance abuse issues precluded him from caring for the girl. The girl became a ward, guardianship was awarded to the Department and she was then placed in a foster home.

Two years later the girl's permanency goal was changed to adoption and she was placed in the home of a couple with a history of caring for special-needs children. As the case progressed further towards adoption, the private agency case worker assigned to the family began attempting to locate the girl's birth certificate, which was necessary to complete the adoption. After a search of Department records proved unsuccessful, the caseworker contacted the OIG for assistance. Using available information, the OIG contacted officials in the county where the girl's first adoption had occurred as well as schools she had previously attended and professional child welfare organizations with whom she had been involved. None possessed an original or copy of the birth certificate. The OIG located the attorney who had handled the original adoption who agreed to review the adoption record, however no evidence of a birth certificate was found in the file.

Ultimately, following extensive consultation, it was determined the only recourse was to file a motion for a replacement birth certificate in the county where the initial adoption had taken place. At the hearing, the presiding judge determined that the girl's abandonment in another country following her birth precluded ever locating an original certificate of birth and ruled that a new birth certificate be created based on the final judgment of her original adoption and listing her initial adoptive parents. Two certified copies of the new birth certificate were completed and provided to the private agency handling the adoption. The girl is currently receiving survivor benefits from the Social Security Administration that will cease after she reaches the age of majority. As her cognitive delays will require continued services, she will likely be eligible for Supplemental Social Security Income (SSI) for which a birth certificate will also be necessary.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. When a child becomes active with the Department, the worker is required to secure a copy of that child's birth certificate. If one cannot be found, then the Department or Purchase of Service agency should immediately contact the Guardianship Administrator's Office for assistance.

An announcement with instructions for securing birth certificates was posted on the D-Net.

GENERAL INVESTIGATION 29

ALLEGATION	The Department discharged an employee who had previously been convicted of attempted murder however the firing was overturned through an arbitration appeal.

INVESTIGATION

Although the Department had been aware of the conviction at the time the employee was hired, he had provided false and misleading information suggesting the conviction had been either overturned or pardoned. After an OIG investigation uncovered the true nature of the employee's crime, which involved shooting a 15 year-old girl in the face in response to her allegations he had raped her, it was recommended that his employment be immediately terminated. The Department agreed and discharged the employee, however the decision was overturned by an arbitrator on appeal. The arbitrator's rationale was that since the Department had been aware of the conviction at hire and had allowed the employee to remain in his position for several years, it could not take extreme action against him.

The result of the arbitrator's decision is diametrically opposed to the mission of the Department to ensure the safety and well being of children. By employing an individual who intentionally caused grievous injury to a child that resulted in her being permanently disabled, the Department allows itself to be represented by an individual who has demonstrated a blatant disregard for its own principles.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should appeal the arbitrator's decision on the grounds it is contrary to public policy.

The Attorney General's Office filed a *Notice to Vacate* the arbitration decision. The case is being litigated.

GENERAL INVESTIGATION 30

ALLEGATION

Department Rule 412, which pertains to investigations of licensed child welfare employees, does not address licensed workers who voluntarily relinquish their licenses during pending licensure investigations.

INVESTIGATION

Currently licensed child welfare employees have the right to relinquish their licenses at any time during the administrative hearing process regarding revocation. In one instance, a Department employee resigned and voluntarily relinquished his license following an OIG investigation that recommended his discharge. Eighteen months later the employee applied for reinstatement with the Child Welfare Employee Licensure Board (CWEL). The circumstances leading to the employee's license forfeiture were not reflected in his personnel record.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should amend Rule 412 to provide specific provisions for voluntary relinquishment of a child welfare employee license.

- **A licensee may voluntarily relinquish his or her license at any time.**
- **The voluntary relinquishment of a CWEL during a pending licensure or disciplinary investigation or proceeding shall be recorded in the CWEL files as "*relinquished during licensure or disciplinary investigation or proceeding.*"**
- **Voluntary relinquishment of a license must be filed with the Child Welfare Employee License Division on a form prescribed by the Division. The form must contain an acknowledgment that reinstatement will be subject to consideration of the facts disclosed in any pending licensure investigations or proceedings. Voluntary relinquishment does not divest the OIG of the jurisdiction to complete a pending investigation.**
- **An Application for License from a licensee who previously relinquished shall be considered a Request for Reinstatement rather than an Application for License.**

The Department agrees. The Office of Child and Family Policy has begun the revision process.

2. Section 412.100 should be amended as follows:

Section 412.100 Restoration of Revoked, Suspended or Relinquished License
A licensee may request the restoration of his or her license by submitting a written request to the Board providing specific reasons to support the request. In considering an application to reinstate or grant a license that was relinquished during a pending licensure investigation or administrative proceeding, the Board shall consider any charges filed along with a report or sworn statement by the Office of the Inspector General regarding the evidence developed in the investigation. For the purpose of considering a Request for Reinstatement, the Board shall presume that the facts developed during the investigation or the pending charges are true, when the license was surrendered during a pending investigation or licensure proceeding; the licensee may rebut the presumption for good cause shown. The Board may not reinstate a license where (deleted: it has been shown by investigation and administrative hearing that) it is not in the best interest of the public to do so. Considerations that will be reviewed when making a finding of "in the best interest of the public" include, but are not limited to: the nature of the offense for which the license was revoked; the period of time that has elapsed since the revocation; evidence of rehabilitation; and character references.

The Department agrees. The Office of Child and Family Policy has begun the revision process.

GENERAL INVESTIGATION 31

ALLEGATION	A Department employee was subordinate to an administrator whose direct supervisor was the employee's father.
INVESTIGATION	The Conflict of Interest committee identified the situation as untenable and not in accordance with Department Rule 437, which prohibits an individual from hiring, supervising or evaluating a family member. After considering potential resolutions, the Committee recommended either having the employee's performance be monitored by another manager or reassigning the employee to another position.
OIG RECOMMENDATIONS / DEPARTMENT RESPONSES	**1. The Department should implement one of the recommendations suggested by the Conflict of Interest Committee.** The Department agrees. The employee's performance is being monitored by another manager.

GENERAL INVESTIGATION 32

ALLEGATION

The OIG contributed to a task force examining pre-employment drug testing for Department employees.

INVESTIGATION

The task force was convened to develop a protocol for implementing a process for drug testing potential employees prior to hire. During the course of this process, it was recognized that individuals denied employment by the Department because of a failed drug test could pursue employment with a private agency without being subjected to the same screening. To address this issue, the task force included language in the Pre-Employment Consent Form applicants must sign at the time of testing authorizing the Department to disclose the results of the test to any private agency where the individual might seek employment. The Consent Form also included a release to hold harmless the Department from any liability related to claims of defamation or invasion of privacy. Immediately prior to implementation, the language related to sharing drug test results with private agencies was removed from the Consent Form.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Rule 412 should be amended to provide for automatic suspension or denial of license application after a licensee or applicant has failed a drug test required by Administrative Procedure 24.

The Department agrees. The Department convened a task force that has developed language to amend Rule 412.

PROJECTS AND INITIATIVES

ERROR REDUCTION

Public Act 095-0527 requires the Office of the Inspector General to remedy patterns of errors or problematic practices that compromise or threaten the safety of children as identified in the Inspector General's death and serious injury investigations and by Child Death Review Teams. To accomplish this task, the Inspector General developed training curriculum and initiated the first round of comprehensive trainings of child protection staff in August 2008. Error reduction and risk management literature have taught us that one cannot reduce errors unless one is willing to admit that errors occur.

It is part of human nature, perhaps embedded in pride, to avoid seeing or recognizing our errors. But the fields of medicine, aviation and engineering have offered classic examples of the benefits to introspective organizations in lowering risk of harm to those they serve. The Inspector General's training introduced child protection investigators, their supervisors and managers to the concept of error management – i.e., what can be done to prevent the occurrence of tragic error by applying error reduction methods to child protection investigations of cuts, bruises, welts and abuse allegations of infants and children, since these allegations are often a precursor to the fatality of young children.

As of this annual report, OIG staff have trained over 60% of child protection investigators, supervisors and managers, including all child protection staff in Cook County and the Southern Region. The Juvenile Protection Association[5] has assumed responsibility for this training and has scheduled trainings for the State's Northern and Central Regions. This phase of the training will be completed within the next three months.

Critical Thinking

The basic principles of the Cuts, Bruises and Welts Error Reduction Training include the application of critical thinking skills to investigations. Past errors included investigators' over-reliance on self-reports and the failure to objectively weigh the credibility of informants. At times, some investigators prematurely became anchored to their initial impressions and rejected evidence that contradicted their first impressions. Others operated under a "Rule of Optimism," misinterpreting and overlooking harmful behaviors. Child Protection is a difficult field; many times we do not want to believe that a parent would harm a child, so we cling to an optimistic view, discrediting contradictory facts. To reduce the tendency for these biases, and to lower the reliance on self-reports, investigators must obtain the information necessary to be able to answer questions about who, what, where, when and how in order to seek the truth of a situation by gathering enough information to provide a fair and accurate account of the events that lead to the child's injuries. The training curriculum reviewed these and other key components of investigations, including scene investigations, scene reenactments, timelines and the identification of key informants.

Seeking Collaboration with Medical Professionals

Since this particular training addressed safety risks in allegations of cuts/bruises/welts to infants and children, the training included literature on medical research that involved bruising and child

[5] The Juvenile Protection Association is a private, non-profit, social service agency that contracts with the Department to provide counseling, consultation, professional education and technical assistance services.

development. Children who do not "cruise" do not bruise themselves. Thus, it is rare for young infants to suffer a bruise compared to children who are crawling or walking. Any young infant with a bruise should be seen by a medical professional. However, data from the Inspector General death investigations and review of a random sample of statewide child protection investigations of infants and children with bruises found that in 65% of the investigations, child protection investigators did not record a professional exchange of information with medical providers. Vital information was not shared with the pediatrician or family physician when the information was critical to rendering an opinion. In 31% of investigations of bruising in infants 24 months or younger the parents/caretakers had a history of domestic violence, but this information was not shared with the doctors.

Steps taken to correct these errors and to increase the reliability of information provided to medical professionals included training the investigators on how to dialogue with a doctor to exchange information on relevant facts so the physician can render an opinion of whether the injury is more likely (the standard of evidence for upholding an indicated finding of abuse or neglect on administrative appeal) to be the result of abuse or an accident. Relevant information provided to a medical professional will include whether there was either domestic violence or substance abuse problems in the home, and the caretaker's explanation for the injury. In addition to training investigators on dialoguing with doctors, the curriculum focused on correcting the misconceptions that investigators could not exchange information with a doctor because it biased the doctor's opinion or violated confidentiality. (The *Dialogue with Doctor* guidelines can be found following this section of the Report.)

To help dispel these misconceptions, DCFS committed the resources of its legal division so that a DCFS attorney attended every training to clarify that statute allows investigators to obtain medical information in the course of an investigation and that when requesting a medical opinion, the investigator can provide relevant information to the physician. In addition, the Department adopted the *Referral Form for Medical Evaluation of a Physical Injury to a Child* to increase the probability of a careful consideration by the physician of the risks associated with an injury to young infants and children. This form, originally crafted from hospital emergency room research, was adapted by the Office of the Inspector General for child protection situations. The Illinois Emergency Medical Services for Children (emergency departments throughout Illinois that have pediatric resources and capabilities) reviewed the referral form and the *Dialogue with Doctor* guidelines before the training and judged them useful because of the prompts they offered for risk determination.

Medical professionals are in a unique position to prevent child maltreatment, but as Dr. Hymel, a pediatrician who testified on behalf of the American Academy of Pediatrics to a House Ways and Means Subcommittee Hearing on Improving Child Protection, reported, pediatricians often are not provided the information vital to the child's follow-up care, especially in substantiated cases of abuse. He found that pediatricians tend to dwell on the periphery of the child protection system. But, after child protection concludes its investigation, it is the child's physician who can monitor the child's well-being in subsequent visits.[6] The pediatrician/family physician needs to know if the family has either domestic violence or substance abuse problems in order to provide guidance to the family.

Child protection needs the assistance of pediatricians and family physicians to lower risk of harm to infants and children. If child abuse and neglect is going to be combated, the village providing the safety net has to include the child's physician and professionals and family members who are invested in the well-being of the child.

[6] Testimony of Kent Hymel, MD, FAAP on behalf of the American Academy of Pediatrics, House Ways and Means Subcommittee on Human Resources Hearing Improving Child Protection Services, May 23, 2006.

Child Centered Collaterals

The Inspector General recommended several procedural changes for child protection investigations of cuts/bruises/welts. These changes were accepted by the Department. One of the key changes was the addition of child centered collaterals. Previously, investigators were required to interview persons identified by the parent, but were not required to talk to persons whom the child might trust. Older children can be asked, "Who do you feel safe with?" For non-verbal children, investigators can ask older siblings who the baby is special to. They can also ascertain who in the extended family network seems concerned for the child's well-being. The Inspector General found that often relatives or professionals invested in the child's well-being were not interviewed. Sometimes, investigators minimized the importance of these collaterals.[7]

Management Support and Organizational Variables

Any error reduction plan has to require that management ensures that investigators can efficiently and effectively investigate allegations. This means that management must support its investigators by giving them needed supplies and by removing unreasonable obstacles that investigators do not have the time or power to remove. Examples of obstacles include organizations that do not reasonably respond to administrative subpoenas issued during a child protection investigation and identifying compassionate medical providers who will see a child when the family has no insurance. The DCFS Chief of Nursing Services identified medical providers who offer sliding scale fees. This list will be provided to investigators as a follow-up to the trainings because of the questions investigators posed during the trainings.

Investigative shortcuts occur when investigators are overburdened. Each shortcut has the potential of producing a lethal error, or what the error reduction literature calls a "near miss" of a tragedy. Wisely, Public Act 095-0527 required a report on whether adequate staff are available to fulfill the error reduction plan. The act was effective in June 2008. The Inspector General's Office compiled data from the June and October 2008 Quality Assurance Reports on the Department's Division of Child Protection's compliance with caseloads agreed upon in a settlement of a federal lawsuit, the B.H. consent decree.[8] The Inspector General found that during these periods the Department was in violation of the consent decree in the vast majority of child protection teams throughout the state. The graphs following this section show the percentage of teams in each region with investigative caseloads that violate the consent decree. Training amidst blatant caseload violations is more than a challenge to learning. It challenges the good faith that must exist between managers and the field. Since the caseload standards were set in the Federal settlement, investigators have had increased investigative expectations. The Inspector General, Child Death Review Teams and Department Directors have increased investigative expectations to include more tasks, such as implementing home safety checklists, in an effort to lower accidental deaths and injuries, increased monitoring in paramour investigations, and most recently, child centered collaterals for increased child safety.

[7] In the Spring and Fall of 2008, Director McEwen and his Acting Deputy Director of Child Protection issued two memoranda to child protection staff, instructing investigators, supervisors and managers to correct errors that were noted in OIG investigations and in the Department's review of 8,000 child protection investigations. The errors identified included investigators' over-reliance on self reports and minimization of family members' concerns for the child's safety.

[8] B.H. was a federal class action lawsuit filed against the Department in 1988 alleging that children were not being adequately services by the Department. A consent decree, accepted by the Court, was entered in settlement of the lawsuit in which the Department agreed to an upper limit being placed on the number of cases that could be assigned to child protection investigators, placement workers, and intact workers.

Safety Planning
The foundation of a safety plan is a solid investigation. Shortcuts taken in investigations were inevitably taken in safety planning, leaving children vulnerable to potential harm. There is a response cost to investigators when an investigator establishes a safety plan, namely, the obligation to monitor the child and family every five days. Perhaps this extra burden creates a situation ripe for the "Rule of Optimism," where the investigator over-relies on the family to mitigate the risk without the need for monitoring. The error reduction training emphasized the concern that when there is physical abuse to infants and young children, the future of an abuse-free household is unpredictable. These dangerous situations call for orders of protection or protective custody.

In other high risk situations, investigators have to determine whether the safety of the child and the risk of future harm can be managed, and what investigative information is needed to make this decision. The training covered key questions that have to be answered in safety planning: If the alleged perpetrator agrees to move out of the house, where are they going to stay and for how long? Who in the professional community and extended family can monitor the plan and notify DCFS if problems arise? Is the family going to be able to follow through on the agreed upon plan and have they understood the consequences of violating the safety plan? Does a parent's desire for romantic relationships, or companionship, or drugs diminish the parent's ability to protect the child? Does the relative or professional who agrees to help monitor the children understand the safety risks?

Consequences for violating safety plans have to be clear. In some cases, where mothers continue to be involved with an abusive paramour or drugs, a safety plan with appropriate non-custodial fathers should be pursued. This is a rare practice within the Department, despite Federal findings that the Department should involve fathers. During the training, some investigators complained that no matter the risk, some State's Attorneys will not screen a case into court. Child Protection problems in particular communities require follow-up after the trainings. This is where management has to step in. With the assistance of the DCFS Office of Legal Services these problems have to be tackled. Training alone is not enough - it can only hope to raise awareness of issues that need resolution. The training follow-up includes a feedback loop to the field. With the assistance of the DCFS Office of Legal Services, a *Frequently Asked Questions* training email is issued to each team trained, answering questions raised in the training.

Quality Assurance Follow-up to Trainings
Within the next six months, Quality Assurance Teams will review investigations conducted by each team trained in error reduction. Each team trained in error reduction will select an investigation of cuts, bruises and welts that they judge to represent a strong investigation and a second randomly selected investigation to be reviewed by Quality Assurance, to determine whether the team has applied the skills demonstrated in the trainings. In addition, the Inspector General's staff will follow up with field and regional managers to develop further supports for the field investigators. The results of these efforts will be published in next year's annual report.

The Child Death Review Teams
The Error Reduction Training curriculum on Cuts, Bruises, and Welts was shared with the Executive Council of the Child Death Review Teams and a member of the Council attended a training. Prior to this training, the Chair of the Executive Council assisted the Inspector General's Office in developing and delivering an error reduction training on investigations involving mentally ill and substance abusing parents. This training was piloted in the Southern Region and is anticipated to begin statewide, following the Quality Assurance field reviews of investigations of cuts, bruises and welts. The results of the initial Quality Assurance reviews will be shared with the Executive Council.

CANTS 65-A
8/2008

State of Illinois
Department of Children and Family Services

Referral Form for Medical Evaluation of a Physical Injury to a Child

Child's Name:	Date of Referral:
Case #:	Parent's Name:
Caretaker's Name:	Caretaker's Relationship:
DCFS Contact:	Telephone:
E-Mail:	Fax:
Supervisor:	Telephone:

Dear Medical Provider:

As part of a pending investigation of child abuse or neglect conducted in pursuant to the Department of Children and Family Services Act [20 ILCS 505/1 *et seq.*] and the Abused and Neglected Child Reporting Act [325 ILCS 5/1 *et seq.]*, the parents of the above child have been directed to bring the child for evaluation and treatment. The following injury or injuries and concerns have been noted:

_____

_____

_____

The parent/caretaker provided the following explanation or explanations of the injury or injuries.

_____

_____

_____

_____

Please complete the sections on the reverse side of this form, and contact me at the above telephone number to discuss the results of your examination relevant to the factors checked, or any other information you have found. In addition, please contact me if I can provide any additional information to you that would be helpful to you in your examination or determination.

Please respond by _____

Sincerely,

_____
Investigation Specialist

Over

I. Explanation of the injury or injuries provided by the parent/caretaker:

_____

_____

_____

_____

_____

II. Please note if any of the following risk factors are present:

☐ Injury in non-cruising infant
☐ Changing explanation of injury
☐ Explanation may be inconsistent with the injury
☐ Explanation may be inconsistent with the child's abilities
☐ Other information seems to contradict explanation for the injury:
☐ Unexplained injury
☐ Un-witnessed injury

_____

_____

_____

☐ Delay in seeking treatment
☐ Various stages of healing of injuries
☐ Bruises on non-prominent areas
☐ Missed medical appointments/missed follow-up treatment
☐ Other:
☐ Injury shaped like an object, hand or pattern
☐ Multiple injuries
☐ Prior injuries

_____

_____

_____

III. Additional injuries or concerns:

_____

_____

_____

_____
Physician's Signature Date

_____
Physician's Name (Printed) Telephone Fax

_____
Street Address, City, State, Zip Code

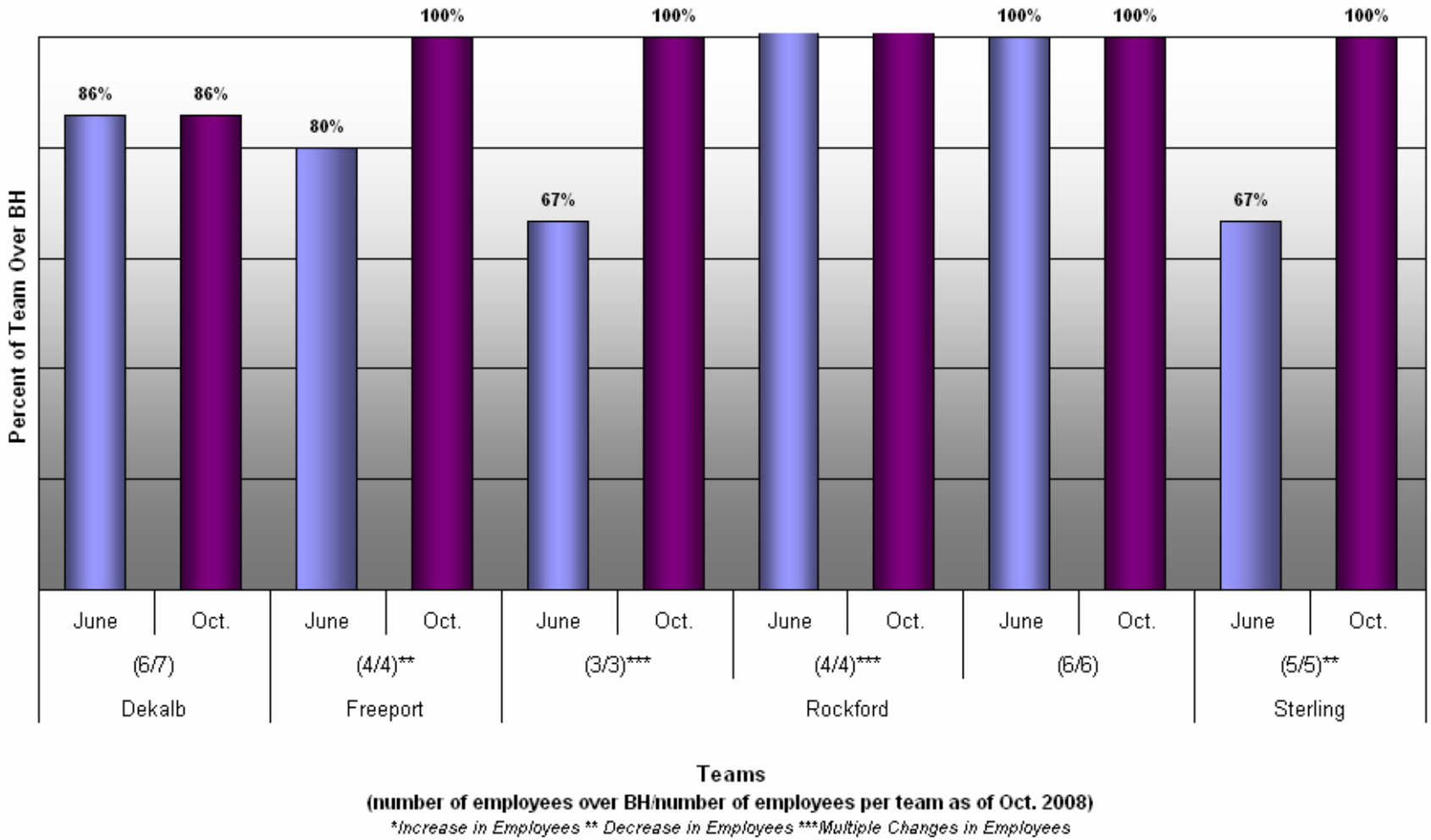
Questions for Doctor

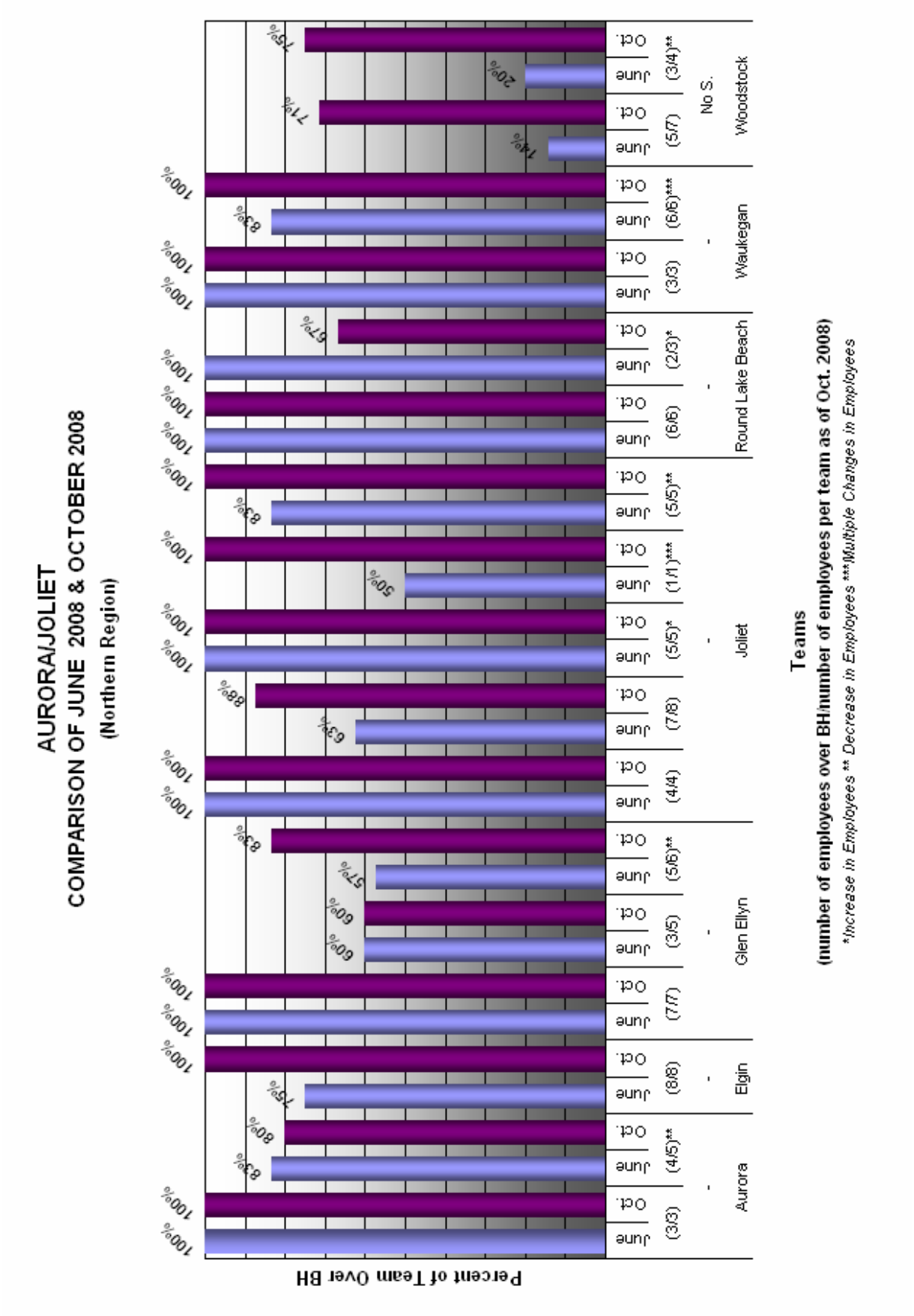
- Establish doctor's specialty and experience.
- What injuries did you find on child?
- How old are the injuries (e.g., when did each injury occur; are injuries the same age; are injuries the result of one incident or several incidents)?
- What would the child's likely immediate reaction be following the injury? How likely is it that the child would be suffering observable pain immediately following the injury?
- What symptoms or behaviors would the child likely exhibit over time following the injury, and over what period of time?
- What explanation was given for each injury and who gave the explanations?
- Who witnessed incident(s) leading to injury(ies)?
- Did person giving explanation witness incident(s) leading to injury(ies)?
- Was there any delay in seeking medical care? How long? Was it justified/explainable?
- Is the way each injury was reported to have occurred consistent with the child's current developmental abilities?
- Is the explanation for each injury consistent with the injury? Why or why not? What else is consistent with the injury?
- Could the injury(ies) be the result of a medical condition or medication? If yes, what has been done/can be done to rule that in or out?
- Are you aware of any injuries to this child prior to the current injury(ies)?
- Do you have any other concerns about anyone in this family (e.g., behavior)?
- Is there any research you can refer me to?
- Is there anything else I should know?

Relevant Facts to Share with Doctor

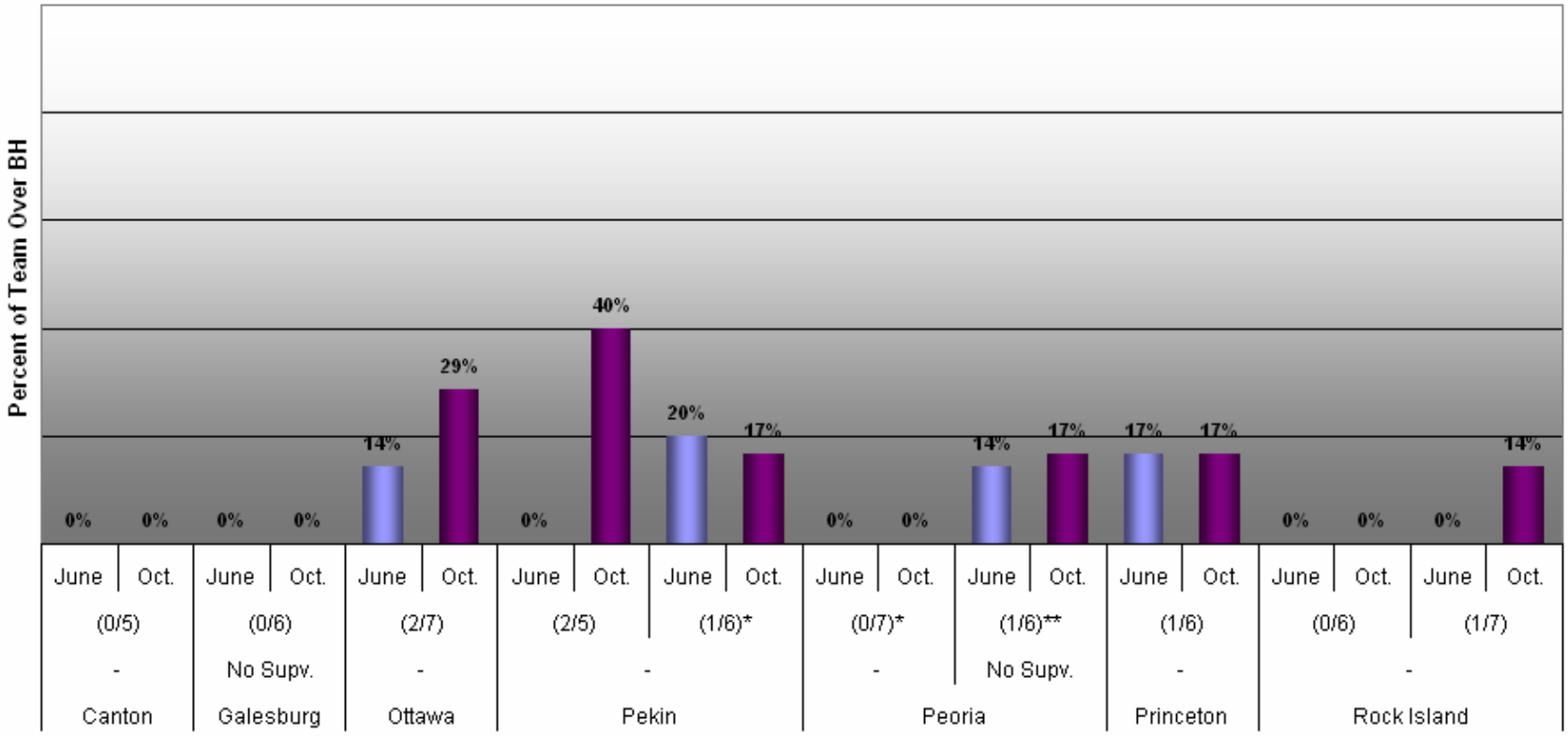
- Whether the incident(s) leading to injury(ies) was witnessed or unwitnessed (if witnessed, who witnessed it)
- What explanation for each injury was offered to you and who offered it
- Whether other explanations have been offered (to whom and when and details)
- Whether the injuries are only occurring in one setting
- Whether the injuries are occurring only with one particular caretaker
- Your observations from the scene investigation (including a detailed description of any objects involved or photos taken, measurements taken, etc.)
- 24-48 hour timeline of sequence of events leading to the incident(s), including any stressors or unusual occurrences
- Whether there was any delay in seeking medical care
- Your observations or information concerning the developmental abilities of the child
- Whether there has recently been a change in family composition or circumstances (e.g., did family member recently lose job or did new boyfriend just move in?)
- Whatever you have learned that corroborates or is inconsistent with information provided by the alleged perpetrator/caretaker (For instance, if parent said that injury was the result of corporal punishment because child is a bad student, what did teacher say about child's performance at school?)
- Prior abuse/neglect history of the family
- Whether there is a history of domestic violence in the home or whether anyone in the home has a possible drug abuse problem or behaviors that suggest mental illness that could interfere with parenting.

Given all the facts we've discussed, do you think it is more likely that the child suffered these injuries as a result of abuse or accident?


ROCKFORD
COMPARISON OF JUNE 2008 & OCTOBER 2008
(Northern Region)
Percent of Team Over BH
86%
86%
80%
100%
67%
100%
100%
100%
100%
100%
67%
100%
June
Oct.
(6/7)
Dekalb
(4/4)**
Freeport
(3/3)***
(4/4)***
Rockford
(6/6)
(5/5)**
Sterling
Teams
(number of employees over BH/number of employees per team as of Oct. 2008)
*Increase in Employees ** Decrease in Employees ***Multiple Changes in Employees


AURORA/JOLIET
COMPARISON OF JUNE 2008 & OCTOBER 2008
(Northern Region)
Percent of Team Over BH
Teams
(number of employees over BH/number of employees per team as of Oct. 2008)
*Increase in Employees ** Decrease in Employees ***Multiple Changes in Employees
Aurora (3/3) (4/5)** (8/8) (7/7) (3/5) (5/6)** (4/4) (7/8) (5/5)* (1/1)*** (5/5)** (6/6) (2/3)* (3/3) (6/6)*** (5/7) (3/4)**
Elgin
Glen Ellyn
Joliet
Round Lake Beach
Waukegan
No S. Woodstock
June
Oct.
100%
83%
80%
75%
60%
57%
50%
63%
88%
67%
83%
14%
71%
75%
20%

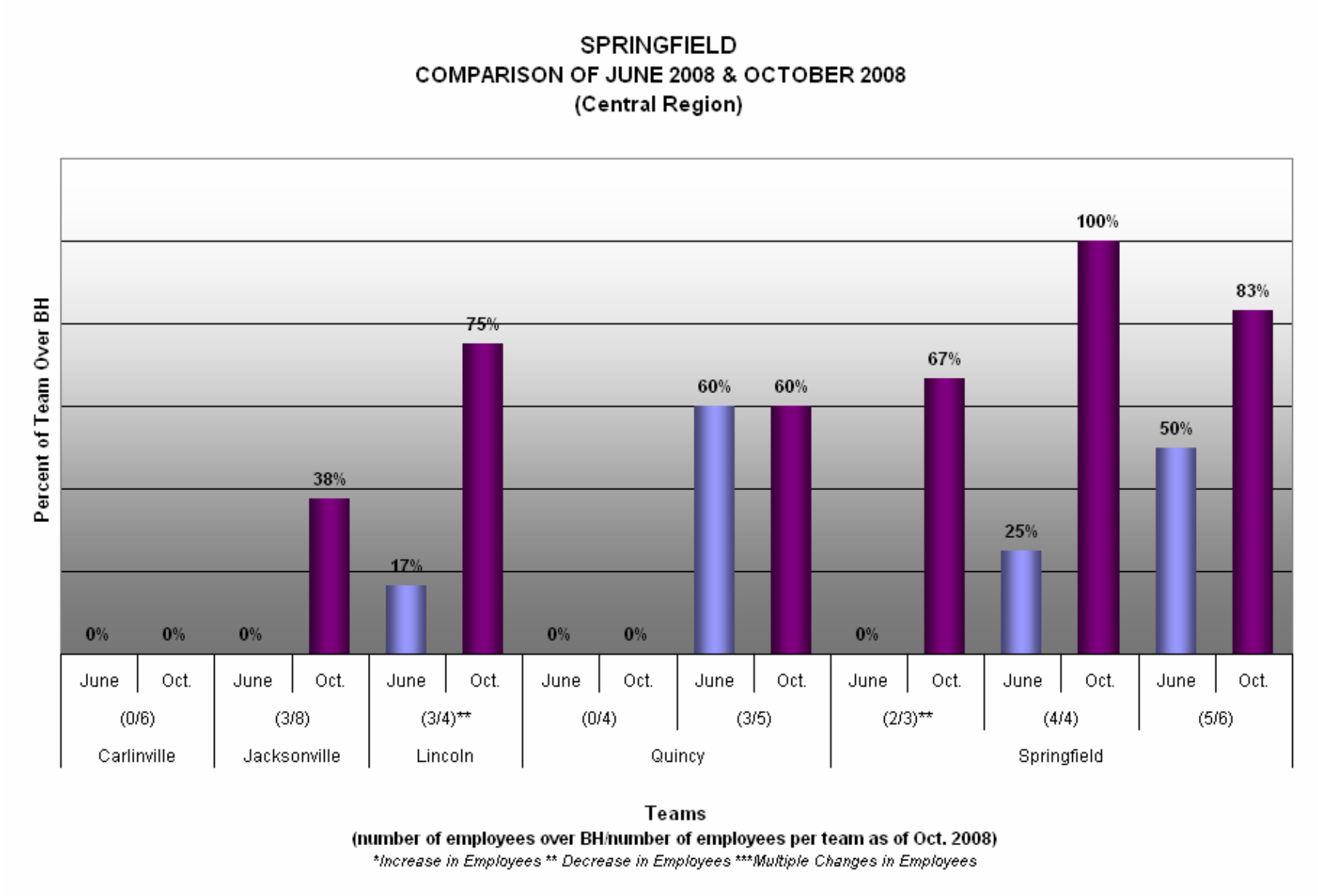
PEORIA
COMPARISON OF JUNE 2008 & OCTOBER 2008
(Central Region)

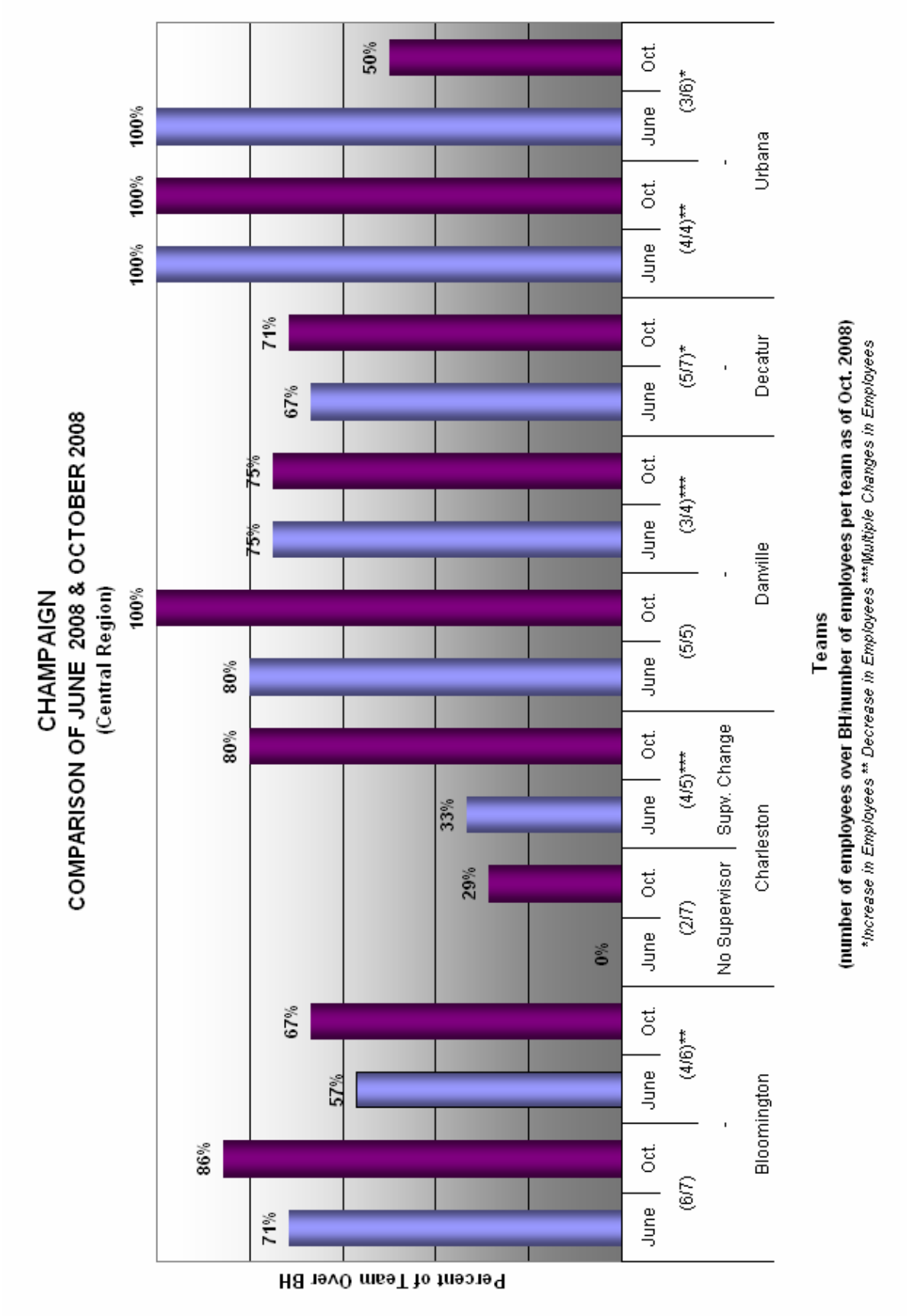


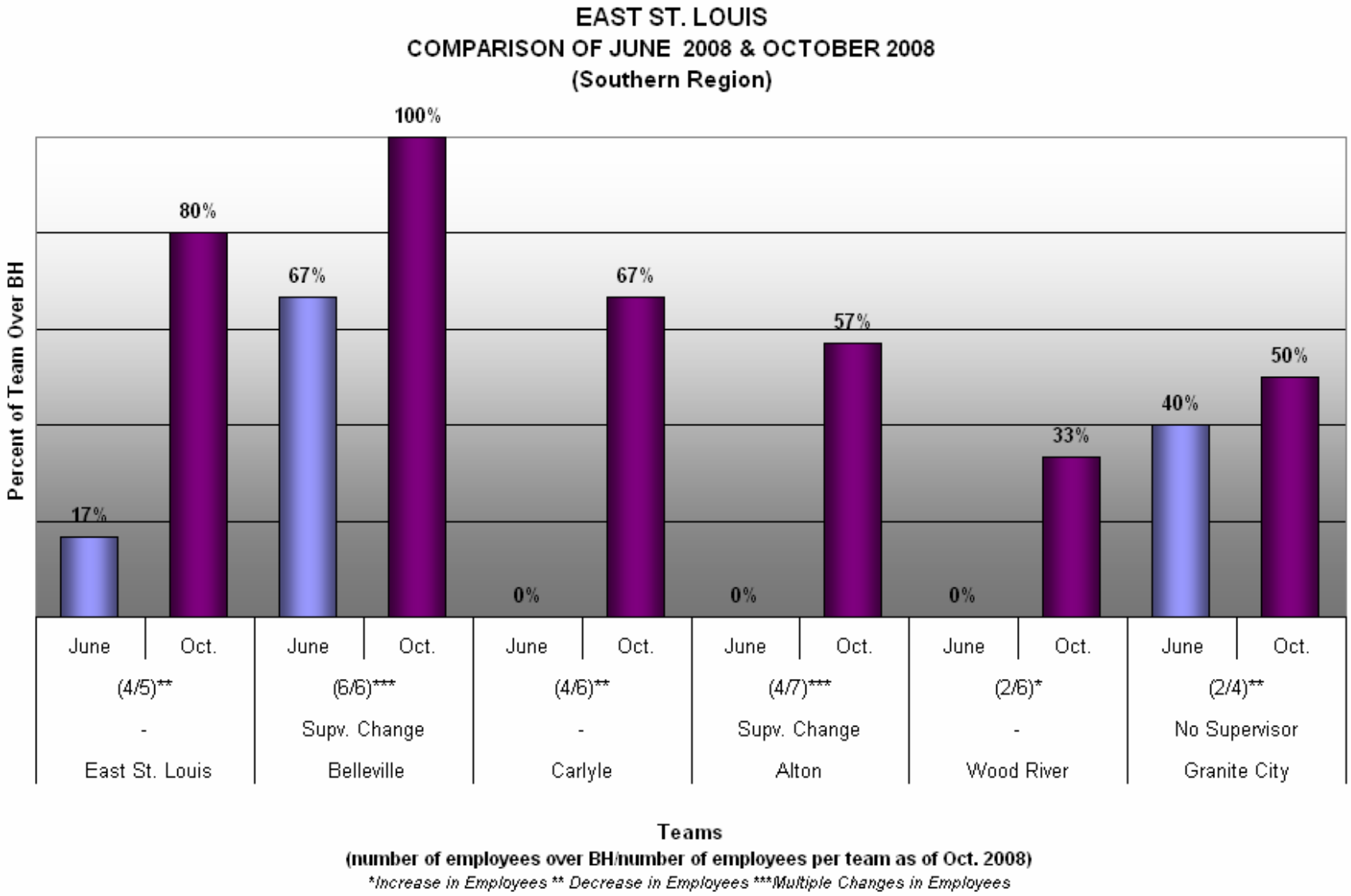
Teams

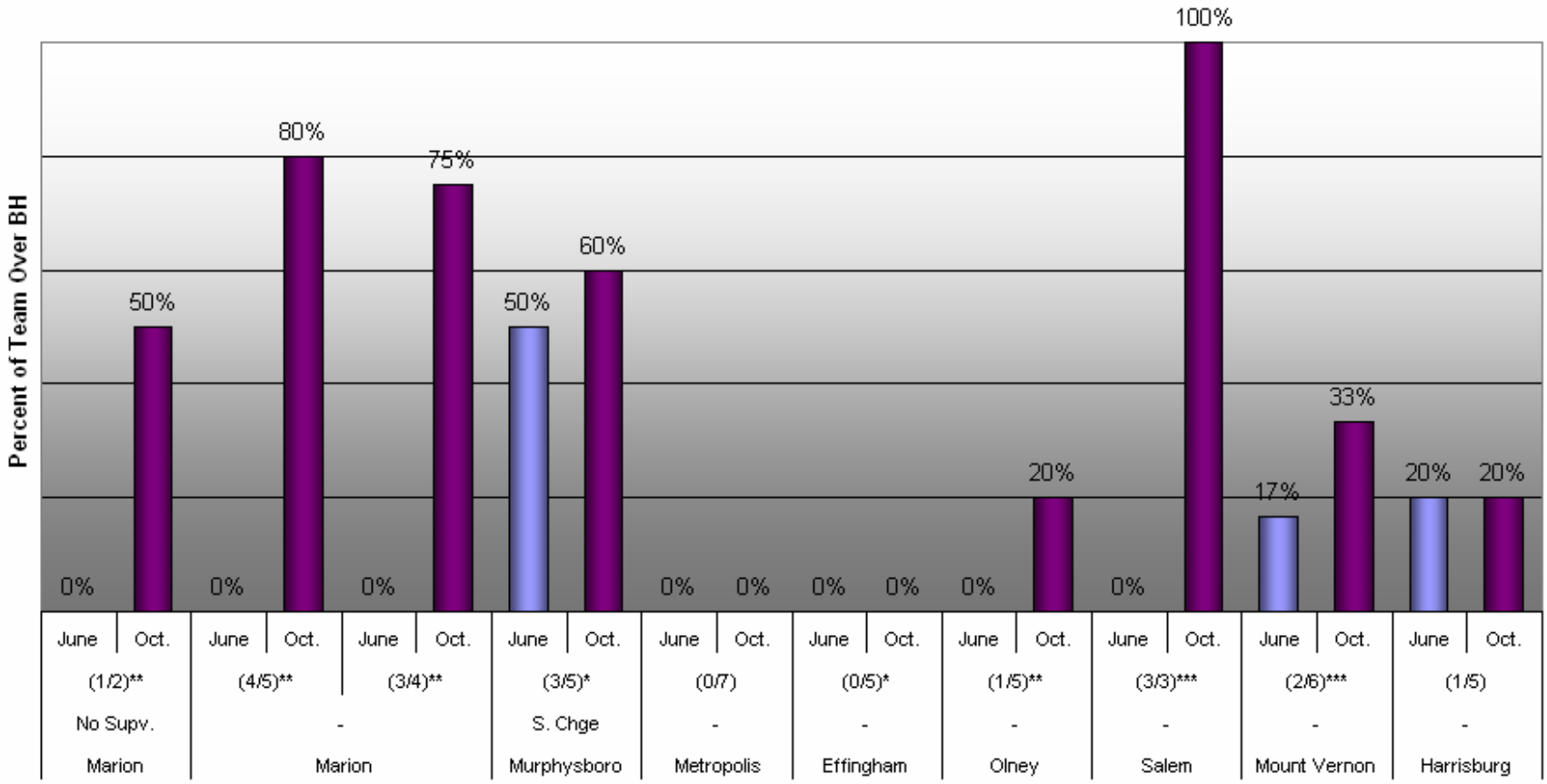
(number of employees over BH/number of employees per team as of Oct. 2008)

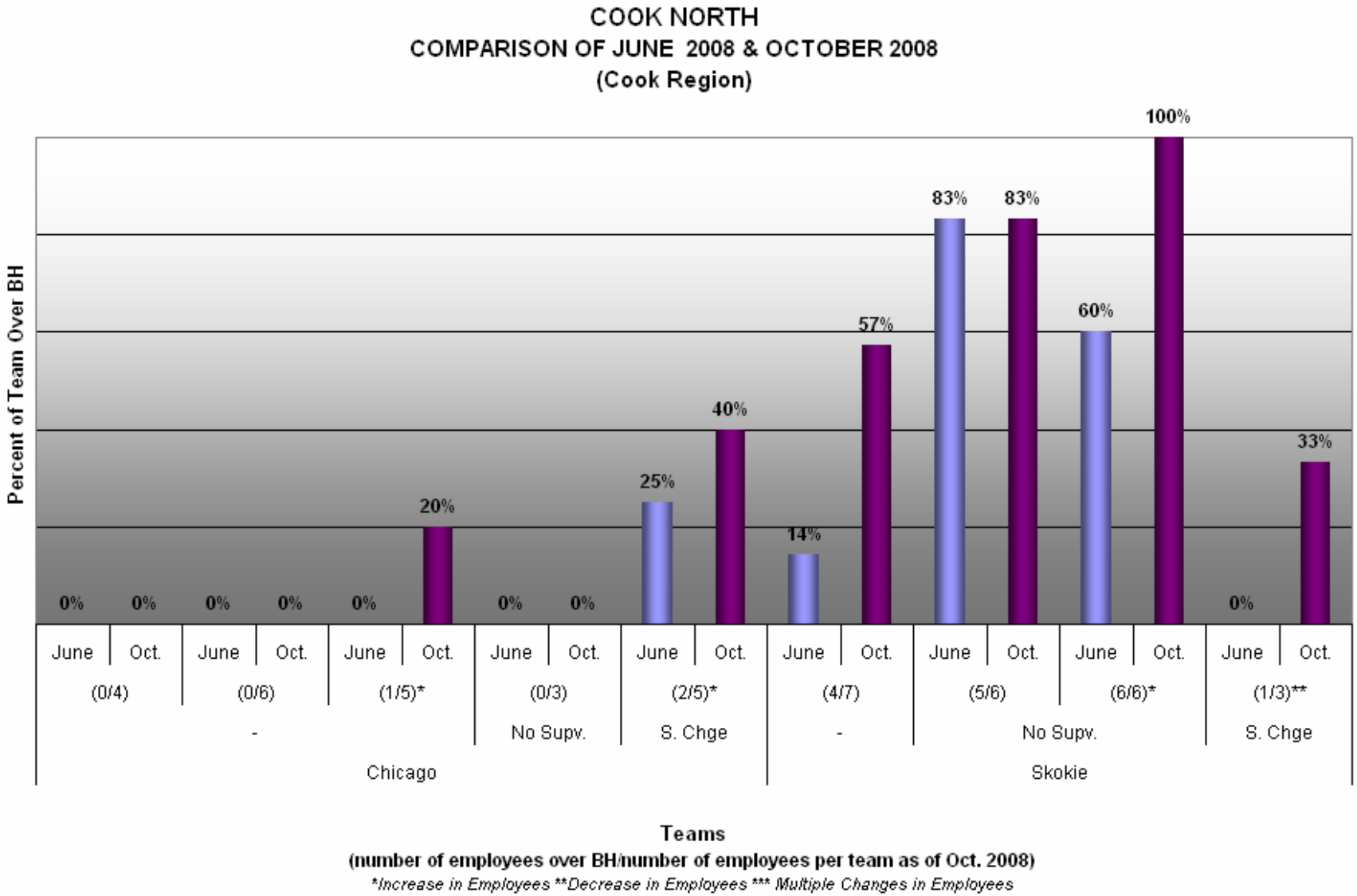
**Increase in Employees ** Decrease in Employees ***Multiple Changes in Employees*

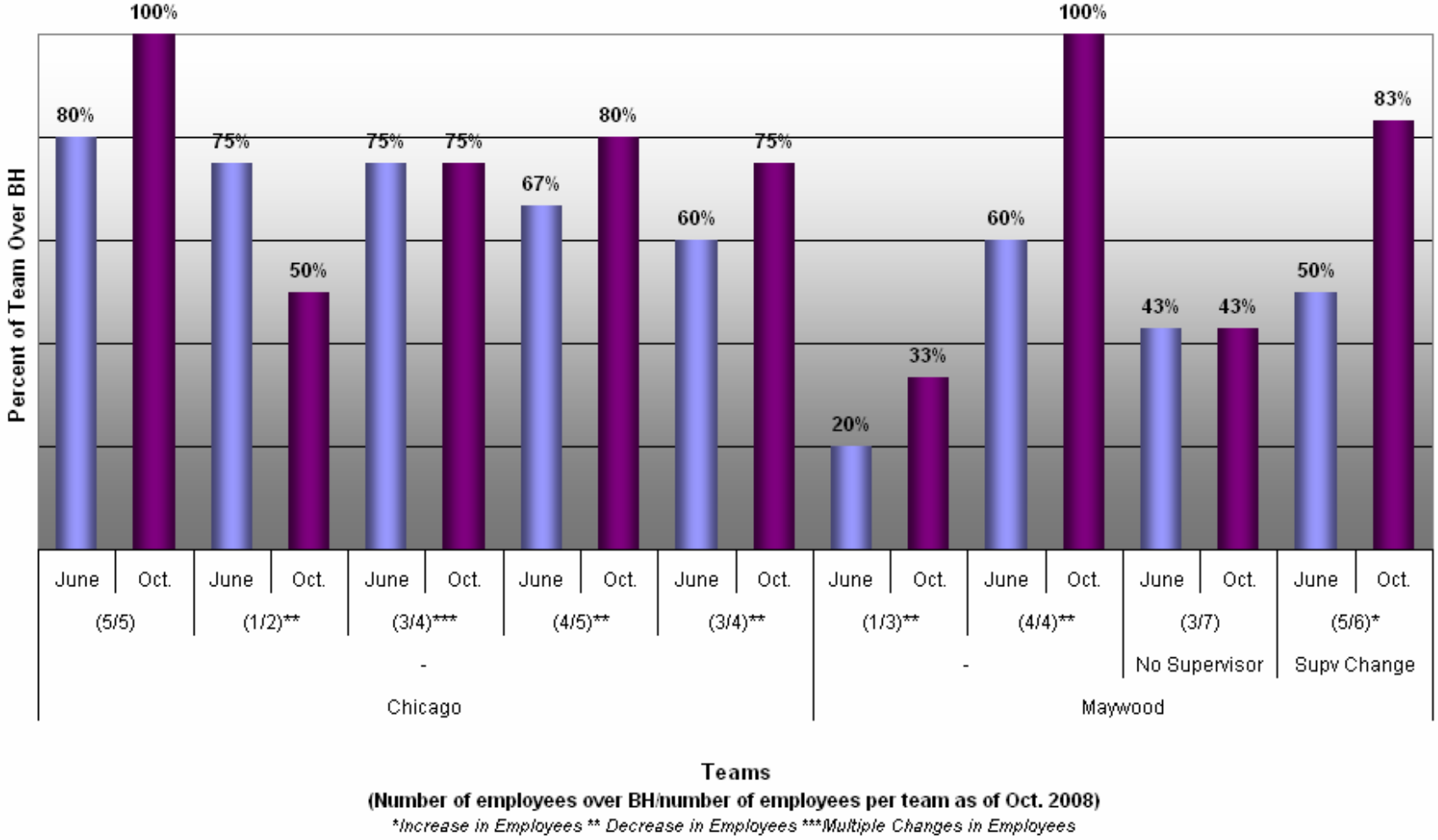

SPRINGFIELD
COMPARISON OF JUNE 2008 & OCTOBER 2008
(Central Region)
Percent of Team Over BH
0%
0%
0%
38%
17%
75%
0%
0%
60%
60%
0%
67%
25%
100%
50%
83%
June
Oct.
(0/6)
Carlinville
(3/8)
Jacksonville
(3/4)**
Lincoln
(0/4)
(3/5)
Quincy
(2/3)**
(4/4)
(5/6)
Springfield
Teams
(number of employees over BH/number of employees per team as of Oct. 2008)
*Increase in Employees ** Decrease in Employees ***Multiple Changes in Employees

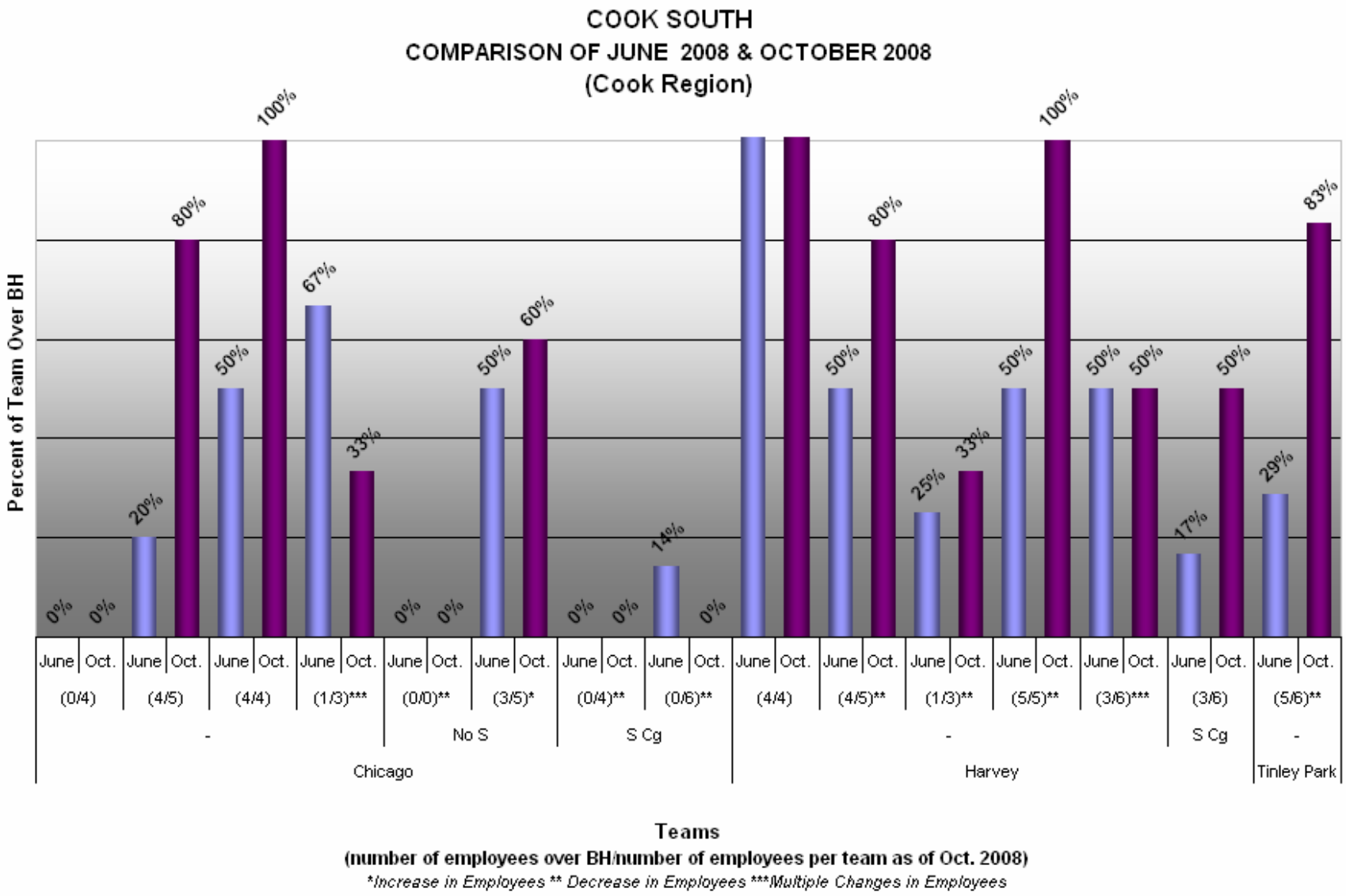

CHAMPAIGN
COMPARISON OF JUNE 2008 & OCTOBER 2008
(Central Region)
Percent of Team Over BH
100%
80%
60%
40%
20%
0%
71%
86%
57%
67%
0%
29%
33%
80%
80%
100%
75%
75%
67%
71%
100%
100%
100%
50%
June
Oct.
(6/7)
(4/6)**
(2/7)
(4/5)***
(5/5)
(3/4)***
(5/7)*
(4/4)**
(3/6)*
-
No Supervisor
Supv. Change
-
-
Bloomington
Charleston
Danville
Decatur
Urbana
Teams
(number of employees over BH/number of employees per team as of Oct. 2008)
*Increase in Employees ** Decrease in Employees ***Multiple Changes in Employees

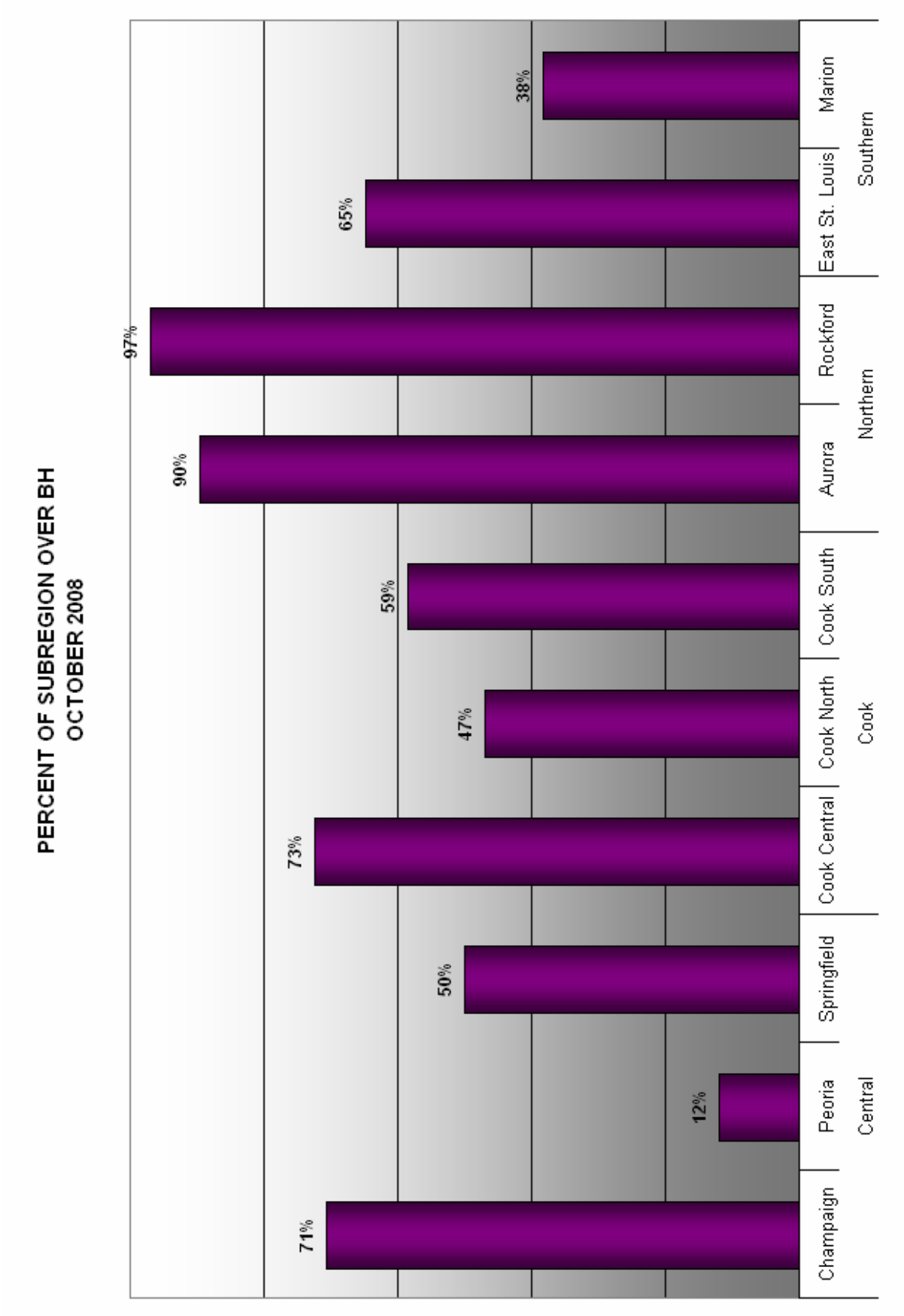

EAST ST. LOUIS
COMPARISON OF JUNE 2008 & OCTOBER 2008
(Southern Region)
Percent of Team Over BH
17%
80%
67%
100%
0%
67%
0%
57%
0%
33%
40%
50%
June
Oct.
(4/5)**
-
East St. Louis
(6/6)***
Supv. Change
Belleville
(4/6)**
-
Carlyle
(4/7)***
Supv. Change
Alton
(2/6)*
-
Wood River
(2/4)**
No Supervisor
Granite City
Teams
(number of employees over BH/number of employees per team as of Oct. 2008)
*Increase in Employees ** Decrease in Employees ***Multiple Changes in Employees

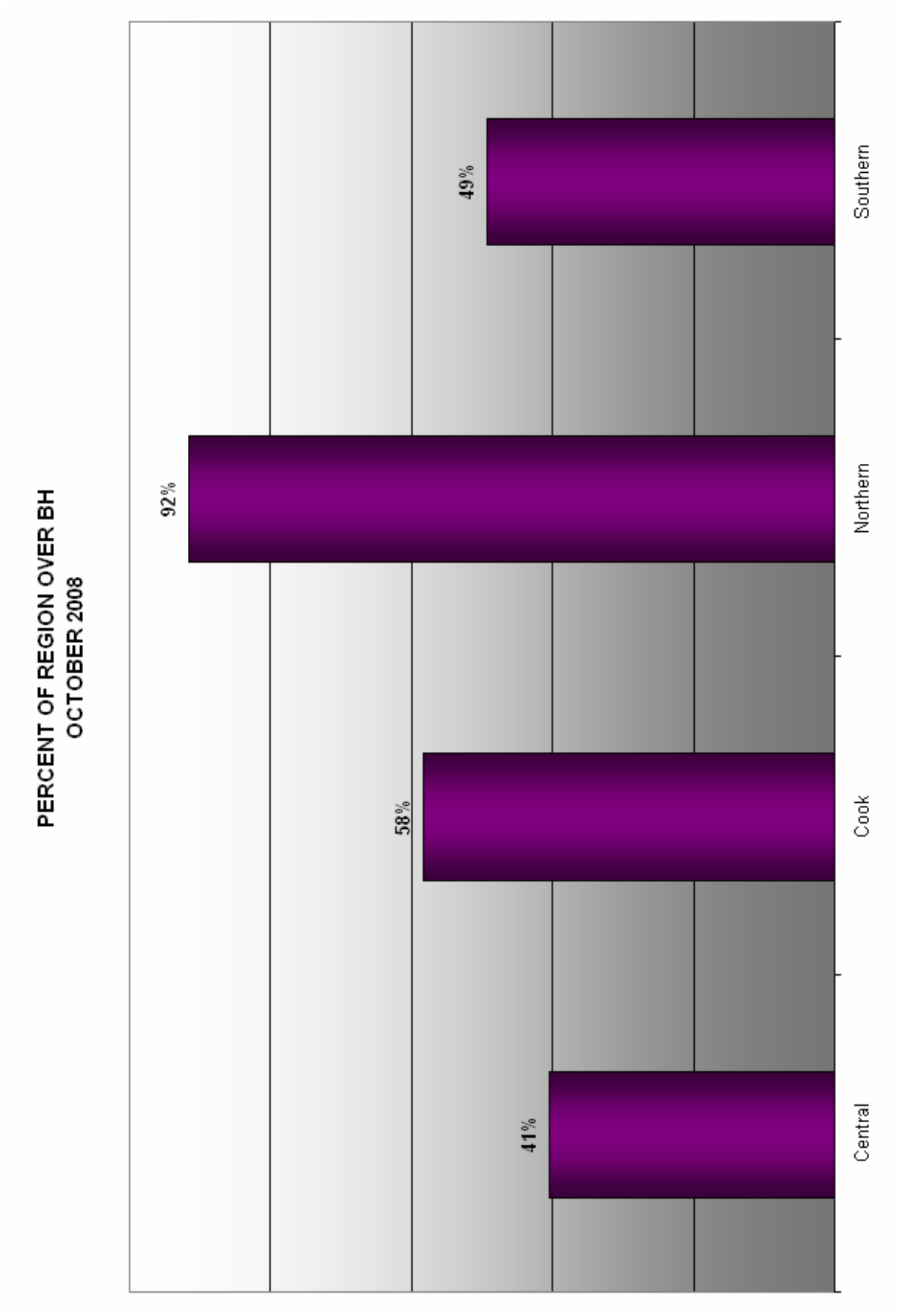

MARION
COMPARISON OF JUNE 2008 & OCTOBER 2008
(Southern Region)
Percent of Team Over BH
0%
50%
0%
80%
0%
75%
50%
60%
0%
0%
0%
0%
0%
20%
0%
100%
17%
33%
20%
20%
June
Oct.
(1/2)**
No Supv.
Marion
(4/5)**
-
Marion
(3/4)**
(3/5)*
S. Chge
Murphysboro
(0/7)
-
Metropolis
(0/5)*
-
Effingham
(1/5)**
-
Olney
(3/3)***
-
Salem
(2/6)***
-
Mount Vernon
(1/5)
-
Harrisburg
Teams
(number of employees over BH/number of employees per team as of Oct. 2008)
*Increase in Employees ** Decrease in Employees ***Multiple Changes in Employees


COOK NORTH
COMPARISON OF JUNE 2008 & OCTOBER 2008
(Cook Region)
Percent of Team Over BH
0%
0%
0%
0%
0%
20%
0%
0%
25%
40%
14%
57%
83%
83%
60%
100%
0%
33%
June
Oct.
(0/4)
(0/6)
(1/5)*
(0/3)
(2/5)*
(4/7)
(5/6)
(6/6)*
(1/3)**
-
No Supv.
S. Chge
Chicago
Skokie
Teams
(number of employees over BH/number of employees per team as of Oct. 2008)
*Increase in Employees **Decrease in Employees *** Multiple Changes in Employees


COOK CENTRAL
COMPARISON OF JUNE 2008 & OCTOBER 2008
(Cook Region)
Percent of Team Over BH
80%
100%
75%
50%
75%
75%
67%
80%
60%
75%
20%
33%
60%
100%
43%
43%
50%
83%
June
Oct.
(5/5)
(1/2)**
(3/4)***
(4/5)**
(3/4)**
(1/3)**
(4/4)**
(3/7)
(5/6)*
-
No Supervisor
Supv Change
Chicago
Maywood
Teams
(Number of employees over BH/number of employees per team as of Oct. 2008)
*Increase in Employees ** Decrease in Employees ***Multiple Changes in Employees


COOK SOUTH
COMPARISON OF JUNE 2008 & OCTOBER 2008
(Cook Region)
Percent of Team Over BH
0%
0%
20%
80%
50%
100%
67%
33%
0%
0%
50%
60%
0%
0%
14%
0%
100%
100%
50%
80%
25%
33%
50%
50%
50%
17%
50%
29%
83%
June
Oct.
(0/4)
(4/5)
(4/4)
(1/3)***
(0/0)**
(3/5)*
(0/4)**
(0/6)**
(4/4)
(4/5)**
(1/3)**
(5/5)**
(3/6)***
(3/6)
(5/6)**
-
No S
S Cg
-
S Cg
-
Chicago
Harvey
Tinley Park
Teams
(number of employees over BH/number of employees per team as of Oct. 2008)
*Increase in Employees ** Decrease in Employees ***Multiple Changes in Employees


PERCENT OF SUBREGION OVER BH
OCTOBER 2008
71%
12%
50%
73%
47%
59%
90%
97%
65%
38%
Champaign
Peoria
Springfield
Cook Central
Cook North
Cook South
Aurora
Rockford
East St. Louis
Marion
Central
Cook
Northern
Southern


PERCENT OF REGION OVER BH
OCTOBER 2008
92%
58%
41%
49%
Northern
Cook
Central
Southern

ETHICS

Child Welfare Ethics Advisory Board

The Child Welfare Ethics Advisory Board was formed in March 1996 as an advisory body to the DCFS Inspector General. Its members are an interdisciplinary group appointed by the Inspector General.[9] Individual Board members provided consultation to the Inspector General throughout the year as needed.

The Child Welfare Ethics Advisory Board formally met once during the year to consider ethical issues raised in a matter involving a DCFS employee/licensed foster parent, who, with her husband, desired to provide a long-term placement for a DCFS ward. In an effort to expedite the placement process, and on State time, the employee appeared in court and expressed a strong interest in having the ward placed in her home. The Board considered whether the employee's actions in going to court on behalf of the ward were sufficiently improper as to prevent placement in the employee's home. The Board also considered any potential future conflict caused by the employee appearing in the same courtroom as both a caseworker and a foster parent. Following the Board's discussion, the Inspector General recommended that the ward's placement with the employee/licensed foster parent proceed if it was determined to be clinically appropriate.

DCFS Ethics Officer

The Illinois Governmental Ethics Act requires the Secretary of State to send a Disclosure of Economic Interests form each year to state employees falling within the scope of the Act. The Act also requires the Inspector General, as Ethics Officer for DCFS, to review the statements of economic interest before they are filed with the Secretary of State. The Department developed procedures for filing the economic interest statements, which are detailed in Chapter 3.11 in the DCFS Employee Handbook. Each year prior to 2008, the Chief of Staff for the Department of Children and Family Services mailed to the home addresses of those employees required to submit economic interest statements instructions to submit the completed statements to the Inspector General, as Ethics Officer, for review. The instructions emphasized that the Inspector General's Office was responsible for forwarding the statements to the Secretary of State by the May 1 deadline.

In 2008, without prior notice to the Inspector General's Office, or to DCFS' Legal Department, the Department's Chief of Staff unilaterally changed the process and instructed employees to mail two original forms: one to the Office of the Inspector General and one to the Office of the Secretary of State. This revised set of instructions did not allow for the Ethics Officer's review prior to submitting the

[9] During this fiscal year, the members of the Child Welfare Ethics Advisory Board were:
Michael Bennett, Ph. D., Professor of Sociology, DePaul University
Jennifer Clark, Psy. D., Director, Child Protection Clinical, Cook County Juvenile Court Clinic
Michael Davis, Ph.D., Senior Fellow and Professor of Philosophy, Illinois Institute of Technology's Center for the Study of Ethics in the Professions
Arman Gonzales, M.D., pediatrician
James C. Jones, President and CEO, ChildServ
Jimmy Lago, M.S.W., M.B.A., Chancellor, Archdiocese of Chicago
David Ozar, Ph.D., Professor of Philosophy, Loyola University Chicago
David Schwartz, M.D., John H. Stroger Jr. Hospital of Cook County
Ada Skyles, Ph.D., J.D., Associate Director and Research Fellow, Chapin Hall Center for Children, University of Chicago (Chair)

statements to the Secretary of State as required by the Illinois Governmental Ethics Act and as detailed in the Department's procedures. As a consequence, the Inspector General was able to review the Statements of Economic Interest only subsequent to their filing with the Secretary of State, in violation of the Act. Following discussions with the Inspector General, the Department's Chief of Staff verified that for 2009, the proper procedures outlined in the DCFS Employee Handbook would be followed.

As Ethics Officer for DCFS under the Illinois Governmental Ethics Act, the Inspector General reviewed 701 Statements of Economic Interest submitted by senior DCFS employees. Of the 701 statements submitted, 73 were further reviewed and followed-up for potential conflicts. The Inspector General and the ethics staff noted entries that could constitute conflicts of interest and sent out 20 letters to employees. In some situations, these letters were intended to clarify entries made on the statements, and in other instances, the letters were directed at educating the individual employee about potential conflicts of interest.

In an effort to assist employees in dealing with ethical issues, the Inspector General and the ethics staff began developing short vignettes of conflict of interest situations. These vignettes will outline common situations encountered within the workplace, the ethical issues they present, and suggestions about how to successfully resolve the situation presented. The Inspector General expects these vignettes will be available early in 2009, through a link on the D-Net, or through the publication of a brochure.

Annual Ethics Training

As required by the State Officials and Employees Ethics Act of 2003, state officials and DCFS staff continued ethics training for all new, contractual, seasonal, and temporary employees. The Office of the Inspector General coordinates and monitors the ethics training for the Department, including monitoring new employees' acknowledgements that they have completed the off-line ethics training. The on-line ethics training for state employees consisted of lessons on various ethical dilemmas. There were two training periods (October 1 – December 30, 2007 for DCFS board and commission members, and May 1 – May 30, 2008 for DCFS employees), for which the OIG ethics staff notified those registered to complete the on-line training and monitored their completion status. Upon conclusion of each period, the OIG submitted a report to the Office of the Executive Inspector General for the Agencies of the Illinois Governor. In 2008, 3,036 DCFS employees completed the on-line ethics training for a compliance rate of 99.9%. In addition to DCFS employees, DCFS board and commission members were asked to have their members complete off-line training. In FY 2008, a total of 481 individuals (99.9%) completed the off-line Ethics training.

INTERIM PROTECTIVE ORDERS

On June 1, 2008, amendments to the Juvenile Court Act, passed by the Legislature as Public Act 95-0405, became effective. These amendments concerning abused, neglected, or dependent children were recommended by the Office of the Inspector General and signed into law in August, 2007. They allow the court to utilize Orders of Protection and intensive court monitoring as a means of enhancing parental compliance with required services, thereby helping children remain in their homes. A parent's failure to comply with the Order of Protection could lead to the imposition of consequences for lack of compliance, up to and including removal of the child from the home. Conversely, parents who cooperate and make progress in services are affirmed and supported in their attempt to resolve issues that brought their family to the attention of the Department.

The Child Protection Division of the Circuit Court of Cook County and Presiding Judge Patricia Martin, together with the Office of the Inspector General, the Department of Children and Family Services, the Cook County Office of the Public Guardian, the Cook County Office of the State's Attorney, and the Cook County Public Defender's Office, have been working on developing a Family Interim Protective Order Court in the Cook County Juvenile Court. The sole focus of this Court will be intensive monitoring of intact families under an Order of Protection. Much of the credit for the development of this innovative approach to safely maintaining children in their homes goes to Judge Martin, who has recognized the important role of a special courtroom and will be the judge hearing these cases.

The families involved with this Court will initially be drawn from the Department's Intact Family Recovery (IFR) Program, which provides intensive services to families who come to the attention of the Department, primarily because of the birth of a first or second substance exposed infant. Eventually, the Court will be expanded to include families in which mental health issues are a concern.

COURTROOM TRAINING

The Office of the Inspector General, the Department's Southern Regional Administrator, and attorneys from the Department's Office of Legal Services collaborated in the development and presentation of a full day general courtroom training. The training was designed to assist caseworkers in understanding legal issues relevant to effective case management and courtroom testimony. The OIG attorneys presented material on obtaining and sharing confidential information; and on the amendments to the Juvenile Court Act effective June 1, 2008, which allow Orders of Protection and intensive court monitoring as means of enhancing parental compliance with required services. Approximately forty private agency and Department caseworkers were trained.

TEEN PARENT SERVICES NETWORK TRAINING

Office of the Inspector General Project Initiatives staff continued to work with the Teen Parent Services Network (TPSN) and Dr. Ron Rooney, Ph.D., University of Minnesota, School of Social Work, and author of, *Strategies for Work with Involuntary Clients*. During FY 08, Dr. Rooney completed editing a series of training vignettes that used a Task-Centered approach to assist case managers in their work with pregnant and parenting teen wards. The Task-Centered approach enhances the ability of workers and teen parents to work collaboratively to establish clear goals and identify specific tasks for the teen and case manager to complete. The training video depicts realistic scenarios addressing issues such as arranging for appropriate childcare, steps toward reunification of a teen parent and her child, and domestic violence. In October 2007, Dr. Rooney came to Chicago and incorporated the videos into a broader training that applied the Task-Centered approach to supervising case managers.

In May 2008, Dr. Rooney returned to Chicago to produce additional Task-Centered videos which demonstrated strategies for workers to use to help parents successfully complete educational goals. This film series was designed to assist workers and TPSN clients in addressing and overcoming obstacles to educational attainment. These vignettes cover topics such as identifying an academic program that best suits the needs of a parenting teen, a discussion of GED and alternative school programs, and overcoming test anxiety.

In FY 09, Dr. Rooney will conduct additional training with TPSN workers and supervisors utilizing the Task-Centered education videos to help case managers assist teen wards in completing their educational goals.

OLDER CAREGIVERS

Collaborative Cross Training – The Department on Aging and Child Welfare Join Hands to Support Illinois Older Caregivers

The Office of the Inspector General's Older Caregivers Project staff developed presentations and a two hour training to educate professionals across service areas about the older caregiver population within child welfare. Project staff, in collaboration with the Department on Aging, presented these presentations and trainings to more than 490 professionals in FY 2008. Participants, including hotline staff from the State Central Register and the Executive staff from Illinois' 13 Area Agencies on Aging, were introduced to the efforts across state agencies to respond to the challenges facing older caregivers and the children they have committed to raise. These presentations and trainings focused on the particular needs within each community by describing local projects that assist older caregivers and the children in their homes and providing contact information for local providers. Specific geographic areas targeted in training included the city of Chicago, suburban Cook County, and the metropolitan regions of Rockford, Aurora and Springfield.

SUBSTANCE AFFECTED FAMILY TRAINING

The Office of the Inspector General and the Division of Service Intervention collaborated in the development and presentation of two, six-hour Substance Affected Family trainings. One hundred and thirty-seven Southern Region Child Protection, Intact and Permanency workers were trained. The training was designed to enhance the ability of Child Protection, Intact and Permanency workers to identify signs and symptoms of substance misuse and co-occurring disorders (substance use and mental illness).

Daniel Cuneo, PhD., Forensic Psychologist, and Chair of the Executive Council of the Child Death Review Teams provided trainees an overview of co-occurring disorders. Dr. Cuneo focused on recognizing how the severity of mental illness coupled with substance abuse/dependence affects child safety and treatment decision making. Dr. Cuneo was also instrumental in removing barriers to Southern Region investigators obtaining mental health records in a timely manner during their investigations.

The training also provided an overview of substance misuse, a review of the Substance Affected Family Policy, the Adult Substance Abuse Screen, and the important role collateral informants play in verifying parent/caregiver self-reports. Emphasis was placed on methods and tools useful in integrating a parent's recovery from substance abuse with their assumption/resumption of positive parenting responsibilities. The training utilized didactic presentations, case studies, role-plays, and panel discussions to strengthen workers' assessment and critical thinking skills.

ADULT SUBSTANCE ABUSE SCREEN

The Office of the Inspector General Project Initiatives Staff, in collaboration with the Department, revised the Adult Substance Abuse Screen (CFS 440-5) in FY 2008 to provide a more comprehensive picture of the person being screened. Revisions include the addition of a section that collects mental and physical health information and prescription drug use; as well as a section requiring the screener to identify and speak with a household or extended family member about possible parental substance abuse, domestic violence and child safety concerns. The revisions were piloted by the Office of the Inspector General Project Initiatives staff and reviewed by supervisors and front line workers statewide. Reviewers' comments were incorporated into the final revision. (The revised *Adult Substance Abuse Screen*, CFS 440-5, follows this section.)

CFS 440-5
Rev. 8/2008

ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES
AND
ILLINOIS DEPARTMENT OF HUMAN SERVICES - DIVISION OF ALCOHOLISM AND SUBSTANCE ABUSE

ADULT SUBSTANCE ABUSE SCREEN

Check One: ☐ Investigation ☐ Open Intact ☐ Add On or Placement case

Person Screened: _____ Date of Screen: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ DCFS Case Name: _____ DCFS Case ID#: _____

Person Completing Screen: _____ Check one: ☐ DCP ☐ Intact Worker ☐ Placement Worker

DCFS Office or POS Agency Name: _____

Address: _____ Phone: _____

Supervisor: _____ Phone: _____

Instructions: Check **Yes or No** for each item in each category. Refer any individuals with a **"Yes"** response to any of the **Bolded item(s)** to a Division of Alcohol and Substance Abuse (DASA) provider for a substance abuse assessment.

I. Facts of the case:

Yes	No		Year(s)
☐	☐	**Delivered Substance Exposed Infant**	
☐	☐	Previous DCFS involvement	

Yes	No	Date of LEADS check:	Date of Last Occurrence	Charge
☐	☐	**Drug related criminal charges on LEADS**		
☐	☐	Non-drug related criminal charges on LEADS		
☐	☐	**Was there a police report indicating the presence of a methamphetamine laboratory: Specify:**		

II. Medical and Mental Health History

Yes	No	
☐	☐	Are you currently on any medication prescribed for a medical condition? Complete below.

Diagnosis/Condition	Medication	Dosage	Duration

☐	☐	Do you have or have you ever had a mental health diagnosis?
☐	☐	Are you currently on any medication prescribed for a mental health diagnosis? If YES Complete below.

Diagnosis/Condition	Medication	Dosage	Duration

☐	☐	Has a doctor ever prescribed medication to "calm you down," "help you sleep," or to "help lift depression"? If YES, what medications?
☐	☐	**Have you taken prescription drugs (such as vicodin, valium, oxycotin, others) that have not been prescribed for you? List below.**
		_____ _____ _____
		_____ _____ _____
☐	☐	Do you receive disability benefits?

III. Observation of Person being screened: Directions: If you mark Yes below, circle all that apply.

Yes	No	
☐	☐	**Smell of Alcohol and/or Marijuana**
☐	☐	**Visible drug paraphernalia: e.g. pipes, razor blades, syringe, other (specify):**
☐	☐	Staggering, tremors, slurred or rapid speech, glassy eyed
☐	☐	Unusual or extreme behavior (Overly alert, agitated, paranoid)
☐	☐	Difficulty concentrating, easily distracted, confused

IV. Person being screened: Any bolded item marked Yes must result in a referral for an assessment.

Yes	No	
☐	☐	Are you currently (or have you ever been) in a substance abuse or methadone maintenance treatment program? If yes, where & what year? _____
☐	☐	**Do you use drugs? If Yes, what drugs, how much, and last time used?** _____ _____
☐	☐	**Have you ever felt you should cut down on drinking and/or drug use?**
☐	☐	**Have people criticized your drinking and/or drug use?**
☐	☐	**Have you ever felt guilty about your drinking and/or drug use?**
☐	☐	**Have you ever taken a drink or used drugs in the morning to steady your nerves or get rid of a hangover?**

V. Direction: These questions must be asked of an adult household member or other extended family member.

Collateral Contact Name: _____

Relation to person being screened: _____

Yes	No	
☐	☐	**Does the person being screened have a drug or alcohol problem?**
☐	☐	Do any family members, caregivers, significant others, persons living in the home, or who interact with the child/ren have a problem with alcohol or drugs?
☐	☐	Does the person being screened need protection from anyone?
☐	☐	Are you aware of any indicators of domestic violence?

Waiver of Collateral Contact Requested:

Reason for waiver: _____
_____
_____

Waiver Approved: ☐ Yes ☐ No

Child Protection Specialist's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

VI. Additional Screener Observations and Comments

Instructions: Include any information obtained during the investigation or contained in the case file that would assist the DASA provider in conducting an assessment and/or treatment; e.g. (suspected drug dealing, heavy foot traffic in and out of the home, criminal justice that indicates a substance abuse problem, etc...) Identify family members or other with relevant information about the person being screened.

_____

_____

_____

_____

VII. Referral:

Instructions: Refer any individuals with a **"Yes"** response to any **Bolded item(s)**. Individuals may also be referred for an assessment to "rule out" alcohol or other drug abuse problem. **All referrals for assessment must include: CFS 440-5 Adult Substance Abuse Screen; CFS 440-6 DCFS Referral for Adult Alcohol and other Drug Treatment Services; and CFS 440-7 Consent for Disclosure of Information. Indicate action taken below.**

☐ **No** Referral for Assessment ☐ Referred for Assessment

Name of Assessment Provider: _____ Date: _____

Fax number: _____ Phone: _____

Fax the following documents to the Assessment Provider at the time of referral:

☐ CFS 440-5 Substance Abuse Screen ☐ CFS 440-6 Referral
☐ CFS 440-7 Consent for Disclosure

Address, City: _____

Contact Person: _____

Appointment Date: _____ Time: _____

_____ _____
Screener Supervisor

_____ _____
Date Date

HOME SAFETY CHECKLIST

A Home and Fire Safety Training program was developed and implemented by the OIG Project Initiatives staff in 2003 in response to a number of child deaths and serious injuries resulting from fire and other environmental hazards. As part of this program, the Department issued the Home Safety Checklist in June 2004. The Home Safety Checklist[10] is completed with every family, and families receive educational material with information on safety issues that are germane to the family needs. Since 2004, the Project Initiatives staff have updated and revised the checklist in response to feedback from workers who have been using the checklist with families they serve. In FY 2008, the Home Safety Checklist was revised to provide a more user-friendly Yes/No format to improve uniformity in application and completion. Other revisions made in FY 2008 require workers to separately note whether the home has a working smoke detector, and if the family has a crib for infants. (The revised *Home Safety Checklist for Intact and Permanency Workers*, CFS 2025, follows this section.)

In support of the Home Safety Checklist's safe sleep standards, to prevent infant rollover deaths and to educate vulnerable families about safe sleep practices, DCFS provided its Child Protection field offices with 90 portable cribs. The cribs are intended for distribution to families who do not have appropriate sleeping arrangements for their infants.

Acknowledging the time constraints experienced by Child Protection Investigators, and to encourage distribution of home safety educational materials, the OIG Project Initiatives staff compiled and distributed Home Safety Educational Packets to DCFS field offices. Each packet contains all of the safety information/brochures investigators are required to distribute to families participating in the home safety assessment.

[10] CFS 2025-Home Safety Checklist for Intact and Permanency Workers, CFS 2026-Home Safety Checklist for Parents and Caregivers, and CFS 2027-Home Safety Checklist for Investigation Specialists.

CFS 2025
Rev 05/2008

State of Illinois
Department of Children and Family Services

HOME SAFETY CHECKLIST FOR INTACT AND PERMANENCY WORKERS

INSTRUCTIONS FOR COMPLETING THE HOME SAFETY CHECKLIST

Every year, 120,000 children 14 years of age and younger suffer some form of permanent damage due to unintentional/accidental injuries. Infants and toddlers are at high risk of unintentional injury or death due to their inability to recognize and react to protect themselves from the danger. According to data from the National SAFE KIDS Campaign:

- Accidental, or unintentional, injury is the leading cause of death among children, teens and young adults.
- The five leading causes of accidental injury are burns, motor vehicle accidents, falls, poisonings and drowning.
- Burns and fires are the fourth most common cause of accidental death in children.
- Nearly 75 percent of all burns in children are preventable.
- Nearly 2,900 adults and children die every year in fires or from other burn injuries.
- The majority of children ages 4 and under, who are hospitalized for burn-related injures, suffer from scald burns (65 percent) or contact burns (20 percent).
- Hot tap water burns cause more deaths and hospitalizations than burns from any other hot liquids.

Fire/burns, motor vehicle traffic accidents, suffocation and accidental falls are the leading causes of unintentional deaths of children under the age of five in Illinois. Numerous Illinois children also die each year as a result of domestic violence.

While it may be impossible to eliminate all the dangers children encounter in their homes, one of the most important factors in reducing those dangers is parent education. The **Home Safety Checklist**, when properly used with parents and caregivers, provides an effective home safety assessment and educational tool that will assist in promoting the safety of children.

WHEN TO COMPLETE THE CHECKLIST

Intact Family Cases

Permanency workers shall complete the **Home Safety Checklist**:

- Within 30 days of the case opening regardless of whether a **CFS 2027** was completed by an Investigation Specialist;
- Prior to a major change of life circumstance (e.g., move to a new home, child birth);
- Every six months during the life of the case;
- When a family with an open service case is the subject of a subsequent child abuse or neglect investigation.

Subsequent CA/N Investigations of Families with Open Cases

The Investigation Specialist or the Investigation Specialist Supervisor shall notify the family assigned intact or permanency worker or the worker's supervisor of the subsequent oral report (SOR) of alleged abuse or neglect within 48 hours after assignment of the investigation. The notification shall include the reminder that the worker must complete a new checklist or re-certify the family's previous checklist within **14 days** of the SOR. The intact or permanency worker must also complete a SACWIS case note that documents the worker's current assessment of home safety issues and forward the documentation to the Investigation Specialist. The Investigation Specialist cannot complete the investigation without receipt of documentation that a checklist has been completed.

CFS 2025
Rev 05/2008

State of Illinois
Department of Children and Family Services

HOME SAFETY CHECKLIST FOR INTACT AND PERMANENCY WORKERS

A **Home Safety Checklist Waiver** may be granted by the intact or permanency supervisor if the allegation or allegations of the SOR do not involve inadequate shelter, inadequate supervision, substance misuse, environmental neglect, inadequate food or inadequate clothing. The supervisor must complete a SACWIS supervisor case not documenting the waiver and rationale for the approval.

A **Home Safety Checklist Recertification** may granted by the intact or permanency supervisor if the checklist was completed within six months of the SOR: and the SOR does not involve an allegation of inadequate supervision, inadequate food, inadequate clothing, inadequate shelter environmental neglect or substance misuse; and the intact or permanency worker has completed a walk through of the family's home to confirm that the condition of the home has not changed. The supervisor must complete a SACWIS supervisory case note documenting the approval and rationale for the approval.

Placement Cases
Permanency workers shall complete the **Home Safety Checklist:**

- When a child is placed with an unlicensed relative. The assessment must be completed on the home of the relative.
- When there is a child abuse or neglect investigation of an unlicensed home in which a child is placed.
- Prior to a scheduled unsupervised visit in the home of the parents.
- When there is a child abuse or neglect investigation involving an alleged incident that occurs during an unsupervised home visit.
- Prior to placement of a pregnant or parenting teen in an independent living arrangement.
- When a parenting teen is identified as the alleged perpetrator of abuse or neglect involving his or her child or any child residing in the household.
- Prior to implementation of child care arrangements involving a child for whom the Department is legally responsible when a parent or caregiver plans to use an unlicensed day care home. The assessment must be completed on the day care home.
- Prior to a major change of life circumstance (e.g., move to a new home, child birth).

A **Home Safety Checklist waiver** may be granted by the Intact or Permanency Supervisor if there is an SOR and the family does not have an open service case with the Department; and a checklist was completed for the family within 30 days, and the allegation or allegations of the SOR do not involve inadequate shelter, inadequate supervision, substance misuse, environmental neglect, inadequate food, or inadequate clothing. The Intact or Permanency Supervisor must complete a SACWIS supervisory case note documenting the waiver and rationale for the approval.

A **Home Safety Checklist re-certification** may be granted by the Intact or Permanency Supervisor if the checklist was completed within six months of the SOR; and the SOR does not involve an allegation or allegations of inadequate shelter, inadequate supervision, substance misuse, environmental neglect, inadequate food, inadequate clothing; and the Investigation Specialist has completed a walk through of the family's home to confirm that the conditions of the home have not changed. The Investigation Supervisor must complete a SACWIS supervisory case note documenting the approval for re-certification and the rationale for approval.

Note: When there is an allegation of inadequate shelter, inadequate supervision, substance misuse, environmental neglect, inadequate food or inadequate clothing the checklist should be completed at the time the Safety Determination Form, CFS 1441, is completed.

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HOW TO COMPLETE THE CHECKLIST

The **Home Safety Checklist** addresses fifteen categories of home safety. Each category is supported by safety standards, literature, and straightforward factual information that should be shared with the parent/caregiver. Use the factual information and literature associated with each category to establish an instructive dialogue to educate the family on safety issues.

There are three activities required for each standard:

1. Discuss the safety standard with the parent/caregiver;
2. Indicate the presence or absence of the safety standard;
3. Provide the parent/caregiver with five pieces of literature (PARENTS' *GUIDE to Fire Safety for Babies and Toddlers, Back to Sleep, Never Shake a Baby!, Violence Prevention and Get water wise…SUPERVISE, and A Helpful Guide for Parents and Caregivers)* that you are required to provide the family. This literature can be ordered from Central Stores through normal channels.

For example, once you have discussed the importance of having a working smoke detector and observed that the family has a smoke detector located near their sleeping areas and the smoke detector works, circle "**Yes"** after the standard: **The home has a working smoke detector located near the family's sleeping areas**. If the family does not have a working smoke detector or has a smoke detector that does not work, circle "**No".** A **"No"** response requires a brief explanation in the Comments section.

When the parent/caregiver is provided fire safety literature, circle "**Yes"** to indicate that the required fire prevention literature was provided. The Sleeping standard also requires a comment when a worker does not observe a crib or bassinette for infants age 1 or younger. Some standards are age specific. For example, the standards that discuss burns may not be applicable to older children. When the standard does not apply circle **"N/A".**

When a standard requires the observation of a specific item or items (e.g., smoke detectors, small electrical appliances), you are required to complete the task if the item is readily observable. Do not open cabinets or drawers, move furniture or handle dangerous items. On the last page of the checklist there is a section to make additional comments or identify other hazards.

The home safety assessment is a service provided to the children and families served by the Department. In order for the **Home Safety Checklist** to be effective, the responsibility for its completion must be shared with the parent/caregiver. Use the information provided at the top of page one of the instructions to explain the purpose of the assessment, provide the parent/caregiver a copy of the **CFS 2026 or 2026-S** (Spanish adaptation)**, Home Safety Checklist for Parents and Caregivers,** to use during the assessment, to take notes on and retain for future reference. The formats of the **CFS 2027** and **CFS2026/ 2026-S** differ; use the prompts provided on the **CFS 2027** to locate the corresponding **CFS 2026/2026-S** sections. Sign, date and have the parent/caregiver sign the completed assessment. If the parent/caregiver declines the opportunity to complete the checklist, check the declined box and request that the parent/caregiver verify his or her decision by signing the form. If the parent/caregiver refuses to sign the form, document the negative response on the parent's signature line. Place the completed assessment in the investigative local index file.

Note: The CFS 2027 does not supersede any of the requirements for the completion of the CFS 1441 or CFS 454, HMR Placement Safety Checklist.

Suggest that the family visit the following resources if they have Internet access:
American College of Emergency Physicians, www.acep.org
American Association of Poison Control Centers, http://www.aapcc.org
American Red Cross Health and Safety Services, http://www.redcross.org
National Safe Kids Campaign, http://www.safekids.org

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FIRE AND BURNS

Please circle your answers.

PARENTS' GUIDE to Fire Safety for Babies and Toddlers	Literature Given:	Yes	No
A HELPFUL GUIDE for PARENTS and CAREGIVERS	Literature Given	Yes	No
A functioning smoke detector was observed in the home.		Yes	No

Comments:

1. The home has a working smoke detector near the family's sleeping areas.	Discussed with parent?	Yes	No	
2. The family has a fire escape plan that they practice so that they can react quickly in case of a fire.	Discussed with parent?	Yes	No	

Young children in Illinois are more than three times as likely to die in a residential fire than the rest of the state's population. Working smoke detectors save lives! Instruct the family to change smoke detector batteries when they reset their clocks, SPRING AHEAD and FALL BACK. These standards correspond to numbers 1 - 5 on the **CFS 2026/2026S**.

3. Preschoolers and younger children do not have access to matches or lighters.	Discussed with parent?	Yes	No	N/A
4. The stove oven or burners are not used to heat the home.	Discussed with parent?	Yes	No	

Forty percent of residential fire related deaths among children are caused by child fire-play. Up to two thirds of child fire-play victims are not the children playing with the fire. Instruct the family to place space heaters at least three feet from combustible materials such as furniture, walls and curtains. Other items such as blankets, clothing and paper should be kept a safe distance from the heater. Supervision of children will prevent fire-play as well as other accidents. These standards correspond to numbers 6 & 7 on the **CFS 2026/2026S**.

5. The family's hot water does not come out of the faucet at scalding temperatures.	Discussed with parent?	Yes	No

To measure your hot water temperature, place a thermometer under the stream of water from a kitchen or bathroom faucet. Keep the thermometer in the stream of water until the recorded temperature stops rising. The water temperature may be measured with outdoor, candy or digital thermometers. Your hot water heater should be set no higher than 120° Fahrenheit to prevent scald burns to children. Children's skin is thinner than an adult's skin and infants and young children will suffer partial and full-thickness (second and third degree) burns after ten seconds in 130° F water; four seconds in 135° F water; one second in 140° F water, and one half second in 149° F water. The correct temperature for an infant's bath water is between 96.8° and 102.2° F. Never place your child in a bath or under running water without first checking the temperature of the water.

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6. Pot handles are always turned towards the back of the stove when they are on the stove.	Discussed with parent?	Yes	No	N/A
7. Electrical appliances (e.g., hair dryers and irons) are kept out of the reach of younger children.	Discussed with parent?	Yes	No	N/A
8. Electrical outlets are not overloaded.	Discussed with parent?	Yes	No	

The majority of scald burns to children, especially among those ages six months to two years, are from hot foods and liquids spilled in the kitchen. Kitchens can be especially dangerous for children during meal preparation. Hot items such as coffee, tea, water, food, pots and pan, and lit cigarettes should never be left on tables, countertops or stove topes within the reach of a child. Parents/caregivers should not hold children while they are cooking. (This standard corresponds to numbers 9 and 10 on the **CFS 2026/2026S**.) Children have been burned by appliances they have pulled down onto themselves. Children have also electrocuted themselves by dropping an appliance into water. These standards correspond to numbers 9-12 on the **CFS 2026/2026S**.

9. Extension cords are not under rugs or furniture.	Discussed with parent?	Yes	No

Extension cords can wear out and spark. Worn cords can cause a fire if they spark under a rug or furniture. This standard corresponds to number 13 on the **CFS 2026/2026S**.

10. Electrical outlets are covered when not in use.	Discussed with parent?	Yes	No

Children can be electrocuted if they place small objects in electrical outlets. (This standard corresponds to number 14 on the **CFS 2026/2026S**.)

SLEEPING

Back to Sleep Literature Given: Yes No

Observed individual crib/bassinette for all infants, age 1 year or younger. Yes No

Comments:

11. The infant sleeps alone in a crib or bassinette.	Discussed with parent?	Yes	No	N/A
12. The infant does not sleep with toys, stuffed animals or pillows.	Discussed with parent?	Yes	No	N/A
13. The infant is placed on his or her back to sleep.	Discussed with parent?	Yes	No	N/A

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If there is a child under the age of one in the home, the following information must be shared with the parent/caregiver.

Infants should sleep alone in a crib or bassinette. Infants sleeping in adult beds are 20 times more likely to suffocate than infants who sleep in alone in cribs. The majority of infants suffocate when another person lays over them or when they smother in soft bedding or furniture when their face becomes trapped in the bedding or wedged in a small space such as between a mattress and a wall or between couch cushions.

If the parent/caregiver is without a crib, talk to your supervisor about loaning the family a crib until they can obtain one of their own.

When the infant is in the crib, the sides of the crib must be up; the mattress must be in the low position; the crib must not be placed near a window; window blinds and electrical cords must be out of the reach of the child; pillows, stuffed animals and toys must never be left in the crib with the child. A child must never wear a pacifier on a ribbon or string placed around his or her neck. These standards correspond to numbers 15 - 17 on the **CFS 2026/20206S**.

CHOKING

14. Plastic bags, pins, buttons, coins, balloons, sharp or breakable items are kept out of the reach of the children.	Discussed with parent?	Yes	No	N/A
15. Younger children only play with toys that are too large to swallow, unbreakable and without sharp edges or points.	Discussed with parent?	Yes	No	N/A

Food such as hot dogs, hard candy, grapes, popcorn and nuts are common culprits in choking deaths. Small toys, tiny rubber balls, too small pacifiers, and bits of balloons are common non-food choking hazards. Children are also at risk for becoming entangled in the ties on hood, cords that control window blinds, toys strung across cribs and strings used to attach pacifiers to clothing. As a general rule, any toy that can fit in a toilet paper roll is a choking hazard. These standards correspond to numbers 18 & 19 on the **CFS 2026/20206S**.

DROWNING

Get water wise…. Supervise Literature Given: Yes No

16. Infants and toddlers are never left alone when near a bath, pool, bucket or toilet.	Discussed with parent?	Yes	No	N/A
17. Baby pools are drained when not in use.	Discussed with parent?	Yes	No	N/A
18. Children are always supervised when they are near water.	Discussed with parent?	Yes	No	

A young child can drown in as little as one inch of water. More than half of the drowning victims under the age of one drown in the bathtub during a brief lapse of supervision by the child's parent or caregiver. A child will lose consciousness within two minutes following submersion. Children must always be supervised when they are near water. These standards correspond to numbers 20 - 22 on the **CFS 2026/2026S**.

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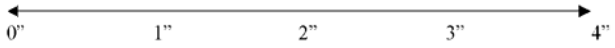
FALLS

19. Infants and toddlers are never left alone on changing tables, countertops, etc.	Discussed with parent?	Yes	No	N/A
20. Furniture that infants and younger children can climb or crawl on is not place near windows.	Discussed with parent?	Yes	No	N/A
21. Baby walkers are not used.	Discussed with parent?	Yes	No	N/A

Children are more likely to die or be severely injured from window-related falls than adults. A screen is not strong enough to hold a child who is leaning against it. Screens are designed to keep insects out of the home, not to keep children from falling out the window. Children have fallen from windows that were open as little as four inches. Children crawling or jumping on beds are at risk of falling from open windows. Supervision is the key to keeping children safe from injury. (These standards correspond to numbers 23-25 on the **CFS 2026/2026S.**)



POISON

22. Cleaning products, pesticides, medicine and liquor are kept out of the reach of children.	Discussed with parent?	Yes	No	N/A
23. The above products (#22) are not kept in food containers or soft drink bottles.	Discussed with parent?	Yes	No	N/A
24. Paint is not chipping or peeling off the walls or woodwork of the home.	Discussed with parent?	Yes	No	N/A
25. Rodent poison and traps are kept out of the reach infants and younger children.	Discussed with parent?	Yes	No	N/A
26. Toddlers and younger children do not have access to rotten food/trash.	Discussed with parent?	Yes	No	N/A

Poisoning in childhood is frequently due to household cleaning products, medicines, vitamin supplements, plants and cosmetics. Toddlers and preschoolers may be attracted to medicines and vitamins because they resemble candy; cleaning products may look like sweet beverages; cosmetics may smell like fruit or candy. Because young children explore the world by putting things in their mouths, poisoning is a serious risk. Contact the National Poison Control Center Hotline at 1-800-222-1222 if you suspect that your child has been poisoned. The most common way that a child comes into contact with lead is through peeling or chipping paint. If you suspect that the paint in your home contains lead, contact the Illinois Department of Public Health's Childhood Lead Poisoning Prevention Program at 1-800-545-2200. These standards correspond to numbers 26-31 on the **CFS 2026/2026S**.

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Violence

Never Shake A Baby! Literature Given: Yes No
Violence Prevention Literature Given: Yes No

27. The parent/caregiver knows how to calm a crying infant.	Discussed with parent?	Yes	No	N/A
28. The parent/caregiver knows never to shake a baby.	Discussed with parent?	Yes	No	N/A

The number one reason given by a perpetrator for killing an infant is that the infant would not stop crying. Other reasons perpetrators have given for injuring a child is that the child wet or soiled him or herself or the child was perceived as misbehaving. Instruct the family that they should NEVER, NEVER SHAKE A BABY and that they should remind their children's caretakers that they should never shake a baby. This standard corresponds to number 32 on the **CFS 2026/2026S**.

Recommend that the parent/caregiver do the following when their baby is crying.

- Make sure that the baby is not hungry, wet, hot or cold, sick or in pain.
- Offer the baby a pacifier.
- Rock or walk with the baby.
- Sing or talk to the baby.
- Take the baby for a ride in his or her stroller or walk the baby in a snuggly body carrier.
- Play soothing music to the baby.
- Turn on a fan. Babies often like rhythmic noises.
- If the baby is overtired, lower the lights and turn off the television or radio.
- Call a friend or neighbor to baby-sit the child for short periods of time to avoid becoming frustrated and angry.
- As a last resort, gently place the child in his or her crib, close the door and walk away. The parent/caregiver should check on the baby every five or ten minutes until the child stops crying or until the parent/caregiver is calm enough to resume comforting the child.

29. Firearms and ammunition stored in the home are kept in separate locked locations.	Discussed with parent?	Yes	No	N/A

The safest home for children is one without weapons. Parents that keep firearms in the home should always store ammunition and unloaded weapons in separate, securely locked containers. The containers, if possible, should be stored in locations that are unknown and inaccessible to the children. The keys to the containers should always remain under the control of the parents. Fifty percent of all childhood unintentional shooting deaths occur in the home of the victim and nearly forty percent occur in the home of a relative or friend. It is difficult for children under the age of eight to distinguish between real and toy guns. Three year old children have the coordination and strength to pull the trigger of many handguns. In Illinois, it is illegal to allow a 14 year old to have access to firearms if that youth does not have a Firearm Owners Identification Card. This standard corresponds to number 33 on the **CFS 2026/2026S**.

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SUPERVISION

30. Children are left with an appropriate caregiver when the parent/caregiver is not home. Discussed with parent? Yes No N/A

A parent's/caregiver's supervision is the most important factor in keeping children safe from injury. Review the following questions with the parent/caregiver. This standard corresponds to number 34 on the **CFS 2026/2026S**.

The answers to these questions should be YES.

- Does this person want to watch my children?
- Will I have an opportunity to watch this person with my children before I leave?
- Is this person good with children my child's age?
- Has this person done a good job caring for other children that I know?
- Will my children be cared for in a place that is safe?
- Does this person know that a baby should never be shaken?

The answers to these questions should be NO.

- Will this person become angry if my children bother him or her?
- If this person is angry with me for leaving, will he or she take her anger out on my children?
- Does this person have a history of violence that makes him or her a danger to my children?
- Has this person had children removed from his or her custody because he or she was unable to care for them?

AUTOMOBILES

31. Illinois law requires children under the age of eight to be in car or booster seats when riding in a car. Discussed with parent? Yes No N/A

Illinois state law requires any child under the age of eight to be secured in a car seat or booster seat when riding in an automobile. Children eight years of age and older must be secured with a seat belt while riding in an automobile. This standard corresponds to number 35 on the **CFS 2026/2026S**.

32. Young children are never left unattended in an automobile. Discussed with parent? Yes No N/A

The temperature in an automobile can rise extremely fast and lead to death by heat exposure. This standard corresponds to number 36 on the **CFS 2026/2026S**.

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EMERGENCY TELEPHONE NUMBERS

Help the family prepare a list of emergency telephone numbers that include their doctor or clinic, the nearest emergency room, poison control (1-800-222-1222). Post the list by the telephone or another easily accessible location if the family does not have telephone. This standard corresponds to number 37 on the **CFS 2026/2026S**.

ILLNESS

33. The parent/caregiver can recognize signs of illness. Discussed with parent? Yes No N/A

Children that are ill, or becoming ill, will show one or more of the following signs of illness:

- Irregular crying that cannot be consoled
- Irregular sleep patterns
- Runny nose, unusual discharge
- Diarrhea
- Fever
- Coughing or sneezing
- Rashes
- Vomiting
- Poor appetite
- Irregular breathing or wheezing
- Ear pain
- Unusual smell/color of bowel movements
- Pain in the abdomen
- Pain during urination

(This standard corresponds to number 38 on the **CFS 2026/2026S**.)

IMMUNIZATIONS

34. The children are up to date on their immunizations. Discussed with parent? Yes No

The following schedule of immunizations is recommended by the American Academy of Pediatrics, Centers for Disease Control and the American Academy of Family Practitioners. This standard corresponds to number 39 on the **CFS 2026/2026S**.

- Hepatitis B (HepB): given at birth, between 1 – 4 months and between 6 – 18 months
- Diphtheria, Tetanus and Pertussis (DTaP): given at 2,4 & 6 months, between 15 – 18 months, and between 4 – 6 years (and Tetanus and Diphtheria (Td) should be administered between 11 – 12 years)
- Haemophilus influenza type b (Hib): given at 2,4 & 6 months and between 12 – 15 months
- Inactivated Polio (IPV): given at 2 & 4 months, between 6 – 18 months and between 4 – 6 years
- Measles, Mumps and Rubella (MMR): given between 12 – 15 months and between 4 – 6 years
- Varicella (chicken pox): given between 12 – 18 months
- Pneumococcal (PCV): given at 2, 4 & 6 months and between 12 – 15 months

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MEDICAL CARE

35. The children have physical examinations according to their doctor's schedule or the schedule listed below. Discussed with parent? Yes No

Children usually have medical checkups performed by a physician at two weeks; two, four, six, nine, 12, 15 and 18 months; two years and annually thereafter. This standard corresponds to number 40 on the **CFS 2026/2026S**.

OTHER OBSERVED HAZARDS/OTHER COMMENTS

SIGNATURES

Parent's/Caregiver's Signature: Date:

☐ Parent/caregiver declined the opportunity to complete the checklist.

Supervisor's Signature: Date:

Worker's Signature: Date:

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Waiver Request

Worker's Name: Supervisor's Name:

Reason for the request:

Waiver Approved: Yes No

If no, please explain:

Worker's Signature: Date:

Supervisor's Signature: Date:

RE-CERTIFICATION

Date of most current Home Safety Checklist: Date of supervisory approval for the re-certification:

Date of home review for the re-certification:

Worker's Signature: Date:

Supervisor's Signature: Date:

SYSTEMIC RECOMMENDATIONS

Inspector General investigative reports contain both systemic and case specific recommendations. The systemic reform recommendations for Fiscal Year 2008 have been categorized below to allow for analysis of the recommendations according to the function that the recommendation is designed to strengthen within the child welfare system. The Office of the Inspector General is a small office in relation to the child welfare system. Rather than address problems in isolation, the Office of the Inspector General views its mandate as strengthening the ability of the Department and private agencies to perform their duties. Recommendation categories are as follows:

- CHILD PROTECTION INVESTIGATIONS
- CHILD WELFARE LICENSURE
- CONTRACT MONITORING
- COORDINATION BETWEEN DIVISIONS
- INTERAGENCY COORDINATION
- PERSONNEL PRACTICES
- PRIVATE AGENCIES
- SERVICES
- STATE CENTRAL REGISTER
- TECHNOLOGY

CHILD PROTECTION INVESTIGATIONS

General

The OIG reiterates previous recommendations made in FY 06 and FY 07 that prompting questions and guidelines be developed for Child Protection Investigators when seeking an opinion from a doctor about physical injuries.

The Department should consider amending the Risk of Sexual Injury Allegation to include situations in which prior sexual abuse of a minor is confirmed through investigation and the perpetrator of the prior abuse has current access to the child/ren.

With severe, multiple injuries to children, where it is left unclear at the close of the child protection investigation which of the alleged perpetrators inflicted the injury, the investigation should be reviewed jointly by the Child Protection Manager and DCFS Legal Services to ascertain whether any additional investigation may assist in determining which perpetrator was responsible for the abuse and whether to pursue immediate termination of parental rights.

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

Child Protection Managers should be instructed to issue administrative subpoenas to the General Counsel of the Department of Healthcare and Family Services in child protection investigations when they are seeking information related to Medicaid benefit claims.

Fathers
Several OIG investigations have disclosed that the field continues to ignore fathers. The Department should review existing Rules and Procedures to determine where specific directives should be included to require consideration of fathers and paternal family members as caregivers. The Department should administer remedial training around this issue to create a change in behavior.

Mental Health
The Department should adapt questions for Child Protection Investigators to utilize when interviewing mental health professionals to determine a parent's ability to adequately care for his/her children. These questions should be incorporated into Child Protection Investigator training.

Medical
The Department should reiterate the availability of the DCFS Medical Director to consult in cases of medical neglect.

Domestic Violence
A domestic violence specialist from the Division of Clinical Practice and Professional Development should oversee all child protection cases involving domestic violence in the identified field office for at least six months to ensure that these investigations are given the attention and expertise critical for the protection of children and families involved in domestic violence situations.

Parallel Investigations
The Department should immediately approve and disseminate the information transmittal regarding parallel investigations, which clarifies duties and responsibilities between the assigned investigator and the parallel investigator.

In situations where there are abuse and neglect allegations in multiple households involving the same perpetrator and children in different households, the Department should consider a mechanism for opening an additional investigation for risk of harm to children in other households or locations, rather than assigning that portion of the investigation as a parallel.

Notification
The Department must ensure that notifications of investigation findings to mandated reporters from the State Central Register conform to Rule 300.130, and include the name of the child victim.

When the subject of a child protection investigation either relocates during the course of the investigation or vacates the home as a condition of a safety plan, the Child Protection Investigator should procure the new address and inform the State Central Register of that current address prior to closing the investigation to ensure that the subject will receive proper notifications.

CHILD WELFARE LICENSURE
The Department should revise Rule 412 to include a section on Voluntarily Relinquishing a License. This section should include the following:

- A licensee may voluntarily relinquish his or her license at any time.

- The voluntary relinquishment of a CWEL during a pending licensure or disciplinary investigation or proceeding shall be recorded in the CWEL files as "*relinquished during licensure or disciplinary investigation or proceeding."*

- Voluntary relinquishment of a license must be filed with the Child Welfare Employee License Division on a form prescribed by the Division. The form must contain an acknowledgment that reinstatement will be subject to consideration of the facts disclosed in any pending licensure investigations or proceedings, and that voluntary relinquishment does not divest the OIG of the jurisdiction to complete a pending investigation.

- An Application for License from a licensee who previously relinquished shall be considered a Request for Reinstatement rather than an Application for License.

The Department should amend Section 412.100 to provide for the restoration of a relinquished license.

CONTRACT MONITORING

The Department's Office of Contract Administration should assure that contracted agencies submit program plans that meet the service needs of the DCFS client population and that the contracting agency has the resources and ability to meet those needs.

The Department's Office of Contract Administration should require quarterly reports from mentoring and counseling agencies on progress toward achievement of program plan goals, both in relationship to individual clients and, in the aggregate, for all clients served under the contract.

The Department's Division of Budget and Finance must be retrained to ensure critical review of budgets and quarterly reports of both grantees and contractors, including identification of discrepancies between the program plan and the budget.

The Department should not allow counseling services to be provided by bachelor level professionals without adequate supervision.

The Department's Resource Referral Form should be modified to include the service category "therapeutic counseling services."

COORDINATION BETWEEN DIVISIONS

In cases of a shared home, the Pre-placement Questionnaire (CFS 2012) should instruct workers to complete the form with the licensing worker present prior to contacting placement clearance.

The requirement outlined in Procedures 301, Appendix E: Placement Clearance Process regarding a joint site-visit between the licensing worker and placing worker should be included in licensing procedures.

Extended Family Support Staff Managers should meet with DCP Program Managers and Supervisors in Cook County to assure an efficient referral process.

The Division of Service Intervention should meet with management in Cook South to address targeted training on the Substance Affected Family Policy, Procedure 302, Appendix A (2006) and the use of short-term guardianship.

INTERAGENCY COORDINATION

A hospital's Child Protective Services Team should consider changes to their internal procedures to ensure that a child taken into protective custody is referred to the Child Protective Services Team.

The Department should pursue an interagency agreement with the Department of Healthcare and Family Services allowing child protection staff access to Medicaid Benefit Claim information.

PERSONNEL PRACTICES

Rule 412 should be amended to include the following language: It is a requirement of licensure that the applicant has not failed a drug test as required by Administrative Procedure 24 within the last six months.

PRIVATE AGENCIES

A residential center's procedures and staff training should be amended to provide that whenever a client alleges an injury by staff or peers, the client should be seen by the center's nurse, who will document the presence or absence of any injuries.

A private agency that provides respite placements for children with the agreement of the parent and without Department involvement, should consider an intake process that assesses the appropriateness for respite services. Parents with severe mental illness and substance abuse may require more than the voluntary respite placement. Staff could benefit from training on referring clients identified with severe mental illness and dual diagnoses to appropriate programs for services.

A private agency should ensure that when a license application is made for placement of a specific ward, the Licensing Worker informs the ward's assigned Caseworker about the application.

The OIG reiterates its recommendation that private agency contracts should contain a provision requiring private agencies to have an Ethics Code at least as stringent as the Department's Code of Ethics for Child Welfare Professionals.

SERVICES

Case Opening

When a child becomes active with the Department, the worker should secure a copy of that child's birth certificate. If one cannot be found, then the Department or Purchase of Service agency should immediately contact the Guardian's office for assistance.

Extended Family Support

The Department should amend or clarify the Extended Family Support's Program Plan for FY09 to allow caregivers of children who are not the subject of any current case to qualify for Extended Family Support services.

Substance Abuse

The Department should implement a revised Adult Substance Abuse Screen that captures the mental health and medical history of the person being screened and requires identification of collateral sources of information.

STATE CENTRAL REGISTER

The Department should issue a policy memo instructing SCR operators that when a mother delivers a stillborn (20 weeks gestation or more) and either the mother or the placenta tests positive for controlled substances, the State Central Register should immediately initiate an investigation for death by abuse. In addition, the State Central Register should take for investigation an allegation of risk of harm to any children in the home.

The State Central Register Administrator should instruct all State Central Register operators that when an incoming hotline call identifies that the allegation involves "foster parent, foster home, foster child, adoptive parent, adoptive home, or DCFS ward," the SCR data checks must include a Provider Name Search and a check for placements. When the subject and/or home are found to be a provider/facility, both the *Facility* box and the *Facility Type* drop down list must be checked when completing the Intake Summary screen in the State Automated Child Welfare Information System.

The Department and the Archdiocese of Chicago should review and clarify the Joint Protocol, which provides agreed upon guidelines for handling child abuse allegations, to specify under what conditions, if any, the Archdiocese of Chicago should contact the Hotline when the alleged victim is no longer a minor.

The Department should pursue statutory changes to Abuse and Neglect Child Reporting Act to extend the 30-day retention period to six (6) months for unfounded reports made by non-mandated reporters involving licensed foster homes/parents.

TECHNOLOGY

The third check box option on the Safety Plan screen of the State Automated Child Welfare Information System Safety Assessment which permits investigators to indicate that the parent refused to sign, should be removed because it provides child protection workers with an option that conflicts with Rule and Procedure 300 which requires parental consent for the safety plan.

The Department should pursue the use of the Illinois Department of Employment Security New Hire database to identify absent fathers in child protection investigations.

The Inspector General previously recommended a modification of the State Automated Child Welfare Information System so that the system has necessary data to be capable of (1) identifying foster parents when their names are entered into the 'Person Search' option and (2) notifying the Department's Agency and Institution Licensing Unit and Foster Care Licensing Agency when the State Central Register receives a report involving a licensed foster home. The OIG reiterates this recommendation.

The Department must implement security safeguards prior to enabling remote access to SACWIS on personal computers. Office of Information Technology Services must obtain direct approval from the private agency's executive director prior to enabling remote access for private agency employees. Two documents should be developed in connection with remote access: (1) The agency director should sign a form agreeing to notify OITS within 24 hours of the employee's change in status or departure from the agency, and (2) The employee should sign a document specifically acknowledging the confidential nature of the remote access application and agree to ensure that outside persons do not have access to the application. The employee should be informed and agree to the requirement that, in order to maintain confidentiality, the Department prohibits transferring or downloading any confidential information onto their personal computer or email. The OITS should maintain and routinely update a database of remote access to SACWIS users.

The Department should obtain more reliable software to use when reviewing use of internet websites. In an OIG investigation alleging that an employee accessed a particular website, the Department was unable to provide accurate records as to who accessed the site and when the site was accessed.

The OIG found discrepancies between the online and downloadable versions of Rules and Procedures on the internal DCFS website. The Office of Child and Family Policy should ensure that policy changes are updated in both the online and downloadable formats.

RECOMMENDATIONS FOR DISCIPLINE AND CONTRACT TERMINATION

In FY 2008, the Office of the Inspector General recommended discipline of Department and private agency employees for the conduct detailed below. Discipline recommendations ranged from counseling to discharge.

Misuse of Position

- A Child Protection Supervisor engaged in conduct that reflected poorly on the Department when the supervisor attempted to influence the outcome of a traffic stop, suggesting that future professional interaction between the Department and the Police might be affected.

- A Child Welfare Specialist used state equipment to further her private business.

- The Inspector General's Office recommended that the Department issue a "no re-hire" letter to be placed in the personnel file of a Child Protection Investigator who resigned during an investigation of allegations that he made sexual advances toward the subject of an investigation he was conducting.

- A State Central Register Operator attempted to transmit another employee's emails to his personal email account without the knowledge or consent of the other employee.

- An Administrative Case Reviewer demonstrated unprofessional conduct during a case review by suggesting a Department client "be neutered."

- A Department Senior Administrator used the state email system for political purposes.

- An Administrative Case Reviewer suggested, without basis, that a private agency's actions might be explained by racism.

- A Child Protection Investigator attempted to obtain a child's medical record without a signed consent for release of information in a case to which he was not assigned, but in which he had a personal interest. The Investigator also conducted phone calls related to this case from his Department office.

Failure to Properly Assess Risk

- A Child Protection Investigator and Supervisor failed to assess risk of harm prior to returning an infant to her parents. The infant was taken by her grandmother to the emergency room with unexplained bruises to the infant's shoulder and face, after the infant was in the care of the mother's paramour. During the investigation, it was learned that the infant's doctor had previously called the Hotline because of suspicious bruising he had noticed a few months before. At that time, the infant had also been in the care of the mother's paramour. The Inspector General's Office noted that the lack of access to consistent supervision in the child protection investigator's office should be considered a mitigating factor in imposing discipline.

- A Child Protection Investigator unfounded allegations of cuts, welts and bruises, despite the fact that the father, grandmother and treating doctors had all noted a distinct handprint on the side of the baby's head and the mother's explanation for the injury was inconsistent and implausible. Even though the child lived with her father and grandmother at least half of the time, and the incident had occurred in the mother's home, the investigator insisted that the father return the child to the mother. This insistence ignored the mother's demonstrated lack of interest in the child and the risk inherent from the unexplained injuries.

- A Child Protection Investigator and Supervisor failed to take protective custody of a 16 year-old with defensive bruising and for whom there had been previous reports of abuse.

- A Child Protection Investigator failed to assess the safety of a three year-old child, instead deferring to a pre-existing post-divorce custody order. In addition, the investigator's documentation was misleading and deficient in that the investigator (1) identified phone contacts as "in person" contacts, (2) omitted important information from contact notes, and (3) recorded multiple contacts or investigative activity that occurred at multiple locations in a single contact note.

- A Child Protection Supervisor approved the unfounding of an allegation of cuts, welts and bruises at the initial stage of an investigation, despite a three centimeter bruise on a three year-old child's thigh. The child said the bruise was caused by his mother hitting him with a wooden spoon and the mother admitted that she disciplined the child by hitting him with a wooden spoon.

- A Child Protection Investigator failed to obtain relevant police records, interview the mandated reporter and failed to request waivers for required contacts. The Child Protection Supervisor failed to ensure that required investigative contacts were made, prior to the initial unfounding of an investigation initiated because of a father's severely violent behavior.

- A Child Protection Investigator and Supervisor unfounded allegations against a father for twisting one teenage daughter's fingers and breaking several fingernails and choking another teenage daughter, even though the allegations were supported by the police report and the father had been arrested.

- A Child Protection Investigator and a Child Protection Supervisor failed to assess the safety of children (other than the alleged victims) who were living in a perpetrator's home. The OIG recommended that the discipline be mitigated because of staff shortages and the lack of written procedures concerning parallel investigations.

- A Child Protection Investigator and Temporarily Assigned Supervisor failed to identify any safety risks present to two young children (a two year-old and a six day-old infant) in the home with their mother, who had recently been arrested for driving under the influence with a severely high blood alcohol level with the children unrestrained in the car. The mother also had a history of not caring for her older children, had a history of violence with family members, and was not cooperating with services.

Breach of Confidentiality

- A Public Service Administrator accessed the SACWIS system to review a pending child protection investigation concerning a family known to him in his personal life and contacted the child protection manager to express his opinion that the investigation should be indicated.

- A caseworker violated the Department's Code of Ethics by posting public information on the Internet that suggested that the Investigator was revealing confidential information.

- A State Central Register Operator failed to verify that a caller was from law enforcement before sharing confidential information.

Misuse of State Funds

- A private foster care agency counselor submitted a bill for counseling services to more than one family on the same date and time. The counselor also submitted a bill for contractual counseling services provided to one agency while serving as a full-time employee at another agency.

Failure to Cooperate with Investigation

- A State Central Register Operator provided evasive and false answers during an interview with the Office of the Inspector General.

Errors in Service Provision/Investigative Work

- After a father reported that he saw his children with the maternal grandmother, a known drug user who was not to be alone with the children, the casemanager responded by relying on the self-report of the foster parent that she had not permitted the prohibited contact. A month later, when it became clear that the children had been living with the maternal grandmother, the casemanager misled the court about when she first learned of the contact. In addition, the casemanager failed to file licensing complaints after learning of allegations of corporal punishment in two licensed foster homes, and failed to provide needed services to the family.

- An investigation of an allegation of lack of supervision identified that two children were present in the home of a babysitter when one of the children was injured. However, only the child injured was named as a victim and therefore, the second child's father was not notified of the child protection investigation involving the babysitter. The Child Protection Investigator and Supervisor ignored uncontested information from a prior unfounded report that disclosed that the primary caretaker of the second child was her father.

- A Child Protection Supervisor failed to act when she learned that a mother had not consented to the safety plan implemented for her child.

- A private agency Program Supervisor conducted an inadequate foster home license renewal monitoring visit when she failed to examine rooms that were secured by padlocked doors, failed to gather family information for assessment purposes and to update an existing home study, and failed to obtain a background check of a child care provider named in a Supervision Plan for foster children. The OIG recommended that discipline be mitigated by the agency staff shortages when the employee assumed responsibility for the foster care program.

- A Child Protection Investigator failed to notify the private licensing agency when a licensed foster parent was the subject of a child protection investigation. Although the Hotline information identified the subject as a possible foster parent, the investigator failed to conduct a database search to confirm the licensed status of the subject.

- Two Child Protection Investigators failed to refer an adoptive family with children in crisis for adoption preservation services, and failed to complete detailed data checks on subjects of the investigation. One investigator also failed to contact an adoptive family's licensing worker while investigating an allegation of substantial risk of injury.

- A Child Protection Investigator failed to interview the victim, the reporter, and the perpetrator and failed to conduct a criminal background check. The Investigator also failed to arrange for interpreter services for a Spanish speaking mother and child victim. The Supervisor approved the closing of the investigation without these required contacts.

- A Child Protection Mandate Investigator failed to determine the presence or absence of an injury to the child's knee in an investigation for allegations of cuts, welts, and bruises to a 13 year-old.

- A Child Protection Investigator threatened to take custody of children after the closure of the investigation. In addition, during the investigation, the investigator failed to obtain mental health records or interview mental health professionals to confirm self-reported information.

- A Child Protection Investigator and a Child Protection Supervisor failed to secure appropriate drug treatment through the DASA initiative during an investigation involving substantial risk of harm and environmental neglect with a family that had a history of substance abuse and had recently been evicted from their home.

- A Child Protection Investigator failed to notify the Department's Division of Agency and Institution Licensing or the private agency of a pending child protection investigation in a home licensed by the private agency. The discipline should be mitigated by the fact that the investigator's caseload was higher than permitted by the B.H. Consent decree.

- A Child Protection Investigator behaved unprofessionally during a child abuse and neglect investigation.

- A Child Protection Investigator failed to make and document required contacts in a timely manner.

- A Child Protection Investigator failed to ensure services were offered to a family on a "J" (10^{th}) sequence investigation.

- A private agency case manager failed to conduct required visits to the foster home of a youth with special needs.

Contract Termination

The Inspector General's Office recommended the termination of a Department contract for the conduct detailed below:

> The Department should terminate its contract with a counseling agency that subcontracted with bachelor level counselors for whom the agency provided no supervision.

LAW ENFORCEMENT CASES

Case 1
A former Department employee terminated for fraud and falsification of records was referred to the Illinois State Police for criminal investigation.

Case 2
A Department employee was referred to the Illinois State Police for credit card fraud. The employee remained under indictment until May 2008, when the employee pleaded to a felony charge and was sentenced to 3 years 6 months incarceration.

Case 3
A former private agency employee was referred to the County State's Attorney's Office after transferring a large sum from the agency's bank account to her personal account. In February 2008, the employee pled guilty to theft and was sentenced to 3 years probation with restitution in the amount of $27,900.

Case 4
A former Department employee had used DCFS vouchers for personal gain and was referred to the Illinois State Police for investigation of fraud. The employee was indicted for theft, official misconduct and forgery. The case is pending.

Case 5
A treating psychiatrist was referred to the Department of Financial and Professional Regulation for stating that a patient was free of drugs and legally blind, when neither claim was substantiated. The case is pending.

Case 6
A private agency employee acting as fiscal agent for a Local Area Network (LAN) embezzled money using gift cards intended for clients of the agency and double billing for her work. The employee was referred to the County State's Attorney's Office and to the local police. The employee was successfully prosecuted and sentenced to probation and had to make restitution.

Case 7
After protective custody was taken of a client's children, the client threatened to "shoot up" the DCFS field office. Department staff contacted the Office of the Inspector General. The OIG coordinated efforts with the local police and sheriff's office. The client did calm down and has been cooperating with the Department since that time. The local police and Sheriff's office responded to protect the local office.

Case 8
A former foster parent was referred to the Illinois State Police for fraud related to foster care payments and adoption subsidy funding, when it was learned that for more than five years she claimed and received foster care payments and adoption subsidy payments, during which time the child was living with another relative. The total amount of the payments received was approximately $30,000. The Illinois State Police declined to pursue an investigation.

Case 9
A Department employee who used his state email in violation of the Ethics Act was referred to the Illinois State Police. The Illinois State Police declined to investigate.

Case 10
The Illinois State Police contacted the Office of the Inspector General for assistance in an investigation of fraudulent receipt of child care payments. The OIG was unable to substantiate that the individual was receiving child care payments.

Case 11
The Inspector General for the Department of Housing and Urban Development contacted the Office of the Inspector General for assistance in verifying the residents of a building who were under federal investigation.

Case 12
The Office of the Inspector General referred an individual to the Illinois State Police who impersonated a police officer in calling the DCFS hotline and obtaining confidential information. The individual also falsified a Court Order in an attempt to obtain custody of his child from the child's mother. The State Police declined to pursue the investigation.

Case 13
The Criminal Division of the Internal Revenue Service requested the assistance of the Office of the Inspector General in an investigation involving fraudulent billing by a licensed daycare facility.

Case 14
An Assistant United States Attorney requested the assistance of the Office of the Inspector General in a pending federal fraud case.

Case 15
Investigators from the Office of the Inspector General of the Social Security Administration requested assistance from the Office of the Inspector General to locate a witness in a pending investigation.

Case 16
At the request of the Inspector General of the United States Railroad Retirement Board, the Office of the Inspector General provided assistance in a fraud investigation by locating an individual's sources of income.

Case 17
While assisting DCP by conducting a criminal background check, the Office of the Inspector General noted that the individual was wanted in another state for failure to register after being convicted of child sex crimes. The OIG contacted out-of-state law enforcement, and provided information to local law enforcement in support of arrest and extradition of the individual.

Case 18
The Office of the Inspector General was contacted by officials in another state who were working with that state's Department of Corrections to help an individual who could not remember significant parts of her identity and life. There was reason to believe that she was a past ward who had run from placement in Illinois years ago. The OIG was able to locate significant information, which enabled the individual to secure necessary services.

Case 19
The Office of the Inspector General noted that an anonymous letter sent to local government offices contained a threat against a presidential candidate. The United States Secret Service was contacted, and the letter was provided for their review.

Case 20
An individual received a letter of an "obscene nature," which had the return address of a DCFS office. The Office of the Inspector General investigated and shared information with law enforcement.

Case 21
The Office of the Inspector General received a request for assistance from the Assistant State's Attorney for information about an individual charged with a financial crime. The individual had a history of receiving Department funds.

Case 22
An investigator from the United States Department of State requested the assistance of the Office of the Inspector General in an investigation of a passport crime committed by a DCFS employee.

Case 23
The Office of the Inspector General provided information to Law Enforcement and the Department's Division of Child Protection regarding an individual who was being investigated for sexual molestation. The individual previously held a daycare license and a foster home license was currently pending.

Case 24
Department employees requested assistance from the Office of the Inspector General when an individual made veiled threats against Department employees and began showing up at various Department offices. The OIG worked with security in the offices and also contacted the Illinois State Police.

Case 25
The Inspector General for the Board of Education requested assistance from the Office of the Inspector General to determine the status of a school employee who had been investigated for sexual molestation. School officials had been notified of the investigation, but were not notified of the indicated finding.

Case 26
A DCFS Litigation Attorney needed to locate a witness for a pending case in Circuit Court. The witness was 14 years-old at the time of the event, and was now 25 years-old. The OIG located the witness and provided the information requested.

DEPARTMENT UPDATE ON PRIOR RECOMMENDATIONS

The following Office of the Inspector General recommendations were made in previous Fiscal Years, but were not fully implemented before the Annual Report was issued. The current implementation status of these recommendations is detailed below in the following categories.

- Child Protection
- Contract Monitoring
- Ethics
- Foster Home Licensing
- General
- Medical
- Personnel
- Services
- Teen Parent Service Network

CHILD PROTECTION

The Abused and Neglected Child Reporting Act should be amended to clarify that the Department can share unfounded investigative information during a subsequent child protection or criminal investigation with any persons named in Section 11.1 for purposes consistent with the Abuse and Neglect Child Reporting Act or criminal prosecution (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 4).

FY 07 Department Response: DCFS Legal has assigned an attorney to draft amendments to ANCRA, which address the above issue, as well as other proposed changes to ANCRA, and will submit as a single legislative package. The targeted date of completion is May 2008.

FY 08 Department Update: DCFS Legal has assigned an attorney to draft amendments to ANCRA which address the above issue, as well as other proposed changes to ANCRA, and will submit as a single legislative package. The anticipated date of completion is February 2009.

The Department should ensure that child protection investigations, both unfounded and indicated, are not expunged while a subsequent investigation, involving the same family, is pending (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 5).

FY 07 Department Response: The Department is considering whether to pursue a change in legislation to implement this recommendation.

FY 08 Department Update: The Department is continuing to examine this and other legislative amendments to ANCRA.

Department Procedure 300.70, "Referrals to the local law enforcement agency and State's Attorney" should be amended to include second-degree burns as injuries requiring referrals to local law enforcement and the State's Attorney (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 5).

FY 07 Department Response: Language regarding this recommendation is being drafted and will be submitted to the Office of Child & Family Policy for approval.

FY 08 Update: The OIG's recommendation was based on a request by the CAC. The Department continues to review the feasibility of the recommendation.

Department procedures should be amended to require that in child protection investigations in which the plan is for a family member to obtain private guardianship of the child/ren, the family should be referred to the Extended Family Support Program for assistance in obtaining private guardianship (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 6).

FY 07 Department Response: The draft protocol was reviewed by the DCP Deputy Director and recommendations for changes were submitted to the workgroup. The workgroup is currently reviewing the revisions. Target completion date: December 1, 2007.

FY 08 Department Update: Service intervention has approved the changes to Procedures and sent them to the Office of Child and Family Policy on November 20, 2008. The Office of Child and Family Policy will incorporate these changes through the standard approval process.

The SCR *Call Floor Manual* should be reviewed for accuracy and cultural sensitivity, and revised to conform to the SCR policy outlined in the email dated March 27, 2007 (OIG FY 07 Annual Report, General Investigation 19).

FY 07 Department Response: A draft of the cultural sensitivity section will be completed by December 1, 2007.

FY 08 Department Update: The Cultural Awareness section of the Call Floor Manual has been completed.

SCR staff should participate in remedial training related to working with non-English speaking callers (OIG FY 07 Annual Report, General Investigation 19).

FY 07 Department Response: The language line training will be completed by December 31, 2007.

FY 08 Department Update: The training was provided to SCR call floor staff.

The Department should reformat the Home Safety Checklist for Child Protection Services Workers (CFS 2027) and the Home Safety Checklist for Intact and Permanency Workers (CFS 2025) (from OIG FY 07 Annual Report, Home Safety Checklist).

FY 07 Department Response: Revisions were sent to the Office of Child and Family Policy in November 2007.

FY 08 Department Update: The CFS 2025 and CFS 2027 were revised effective June 21, 2008.

The procedures for completing a CERAP and the decision tree for mentally ill parents should be amended so that the guidelines note the need to assess risk to the child when a parent incorporates a child into their delusional system, even in the absence of overt negative statements (from OIG FY 06 Annual Report, Death and Serious Injury 2).

FY 06 Department Response: The committee revising the safety assessment continues to work on the safety framework protocol. Targeted completion date is June 2007.

FY 07 Department Update: The new safety assessment that is being field tested does not include guidelines that address the need to assess risk when a parent incorporates a child into their delusional system.

FY 08 Department Update: Department procedures require a rule out of dependency. Revised safety enhancement factors have been expanded.

The Department should ensure that available fathers be explored as potential placements. If a safety plan is likely to last longer than six months, the Department should facilitate a legal relationship between the child and the caretaker (from OIG FY 06 Annual Report, General Investigations 11).

FY 06 Department Response: A committee has been formed to revise the safety assessment process. The Committee continues to work on the safety assessment framework protocol. Targeted completion date is June 2007.

FY 07 Department Update: The CERAP draft, currently being field tested, directs the attention of the worker to consider available fathers as potential placements.

FY 08 Department Update: The CERAP draft provides that non-custodial parents should be identified and assessed first for potential out-of-home placement when a safety plan is needed.

Children with increased vulnerability, either because of age or developmental disabilities, who present with a medical condition that could be the result of sexual exploitation, should be referred to the local child advocacy center for a victim sensitive interview to assist in determining if the medical condition is the result of abuse (from OIG FY 06 Annual Report, Death and Serious Injury 3).

FY 06 Department Response: The Department agrees. A memo will be distributed to staff regarding this issue.

FY 07 Department Update: A memo is currently being revised and should be distributed by January 2008.

FY 08 Department Update: A memo dated November 24, 2008 was distributed to Child Protection staff.

The procedures for completing a Child Endangerment Risk Assessment Protocol (CERAP) should be amended so that the guidelines regarding a household member's developmental disability or mental illness direct a worker to consider pursuing a dependency petition (from OIG FY 06 Annual Report, Death and Serious Injury 2).

FY 07 Department Update: The committee has developed a new safety assessment protocol, which is being field tested. The new protocol does not include a prompt to consider dependency.

FY 08 Department Update: Department procedures require a rule out of dependency. The revised safety enhancement factors have been expanded.

Rules and Procedures should be amended to provide that new injuries can raise suspicion regarding old injuries, previously believed accidental, and that when this occurs, investigators need to share new information and work collaboratively with all available professional resources, such as hospital child abuse teams or Child Advocacy Centers (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 3).

FY 04 Department Response: A workgroup to revise Procedures 300 was convened and will address this issue with DCFS Legal for possible liability regarding discussing previously unfounded reports with available professional resources and appropriately documenting a review and consideration of previously unfounded reports in a current investigation. Completion Date: February 2005.

FY 05 Department Update: These items were referred to the Legal Division for an opinion regarding possible legal ramifications. Legal is still assessing these matters.

FY 06 Department Update: The Division of Child Protection Committee has not completed their review and final revisions to Procedures 300. Once completed, the procedures will be returned to the Office of Child and Family Policy to begin the process of approval from JCAR. Implementation date: Spring 2007.

FY 07 Department Update: The Office of Child/Family Policy has forwarded the final draft of Procedures 300 to the Division of Child Protection. The Procedures 300 workgroup is reviewing the final draft and expects completion by December 2007.

FY 08 Department Update: Allegation 11 was amended to address this recommendation.

The new CERAP should eliminate the use of Safety Thresholds and limit the Safety Information Standards to those necessary to good investigative practices (OIG FY 07 Annual Report, Child Endangerment and Risk Assessment Protocol (CERAP)).

FY 07 Department Response: The Safety Workgroup has developed a new draft CERAP that is currently being field tested. The Safety Workgroup has incorporated recommendations received from the OIG into the process as deemed appropriate to the overall models.

FY 07 OIG Response: The preliminary field test for the new CERAP suggests that it is cumbersome and may detract from an investigator's ability to determine whether abuse or neglect occurred and ensure the safety of the child, because it has too broad of a focus. Rather than centering the investigator's attention on good investigation practice to determine the who, what, when, how and where of an investigation and on developing strong safety planning-the tool focuses on broad assessment questions that are more appropriate for an Integrated Assessment after an allegation is indicated.

FY 08 Department Update: Safety thresholds have been eliminated.

The State Central Register should revise the Notice of Indicated Finding sent to parents to comply with Rule 336.60 (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 6).

FY 05 Department Response: This recommendation is under review by the DCFS Legal Division because of the impact it may have on the DuPuy Federal lawsuit.

FY 06 Department Update: Revisions are on hold pending implementation of the changes required by the DuPuy Federal lawsuit. Changes will be implemented as soon as possible, but no later than July 17, 2007.

FY 07 Department Update: Revisions were placed on hold by DCFS Legal due to changes required by DuPuy Federal Lawsuit. As of November 2007, litigation is ongoing and it appears additional changes to the notice form may be required. DCFS Legal will continue to monitor and will draft an updated form when legal issues have been resolved. The anticipated implementation date is May 2008.

FY 08 Department Update: Revisions to the notification letter are in process and will be completed by June 2009.

Provide training and written guidelines for mitigation and development of safety plans, including specific components that should be in place for specific safety concerns, such as violence and physical abuse. The training and guidelines should address the need to consider inclusion of extended family or protective daycare as partners in implementing the safety plan (from OIG FY 06 Annual Report, General Investigations 16).

FY 07 Department Response: The draft CERAP, currently being field tested, does <u>not</u> provide guidelines for mitigation and development of safety plans specifically addressing safety plans with violence or physical abuse issues.

FY 08 Department Update: The OIG and the Department have addressed this issue through the Error Reduction Team Training.

Once a risk is identified, workers need more guidance on how to determine whether the risk is "urgent" or "immediate" (from OIG FY 06 Annual Report, General Investigations 16).

FY 07 Department Response: The draft CERAP, currently being field tested does <u>not</u> provide guidelines on how to determine if risk is "urgent" or "immediate."

FY 08 Department Update: This has been addressed with the latest safety assessment form CFS 1441 and procedure guidelines removing the requirement for "urgent" and "immediate" to support identifying a safety factor.

Add a third box to each safety factor, acknowledging that information for that factor may be "unknown" or "uncertain" and add a section at the conclusion of the factors list for identifying information that needs to be gathered in the future to further assess safety (from OIG FY 06 Annual Report, General Investigations 16).

FY 07 Department Response: The current draft CERAP that is being field-tested provides two assessment tools. The first is used at the outset and permits workers to note that more information is needed before the question can be answered.

FY 08 Department Update: The current draft of the initial CERAP acknowledges the option that more information is needed to assess safety.

Devise a supervisory form to accompany the safety assessment that would allow a supervisor to determine the source of information that formed the basis of the particular safety factor decision and provide a check that basic available objective sources (such as the hotline report, prior child protection investigations, police reports and interviews with police, and criminal history information as required by Administrative Procedure 6) (from OIG FY 06 Annual Report, General Investigations 16).

FY 07 Department Response: The draft CERAP, currently being field-tested does <u>not</u> provide prompts or checks for determining source of information.

FY 08 Department Update: The current draft CERAP identifies the source of the information.

While developing its protocol for investigations of abuse and neglect in religious facilities the Department should develop a general protocol for ascertaining supervisors and administrators to receive official notification. An appointed designee of the Department's Legal Division or the State Central Register should facilitate notification to the proper religious superiors (from OIG FY 06 Annual Report, General Investigations 9).

FY 07 Department Response: The Department is reviewing this recommendation.

FY 08 Department Update: DCFS Legal provided DCP with a draft protocol for review. DCP will utilize this protocol to generate an information transmittal to staff. The anticipated date of implementation is February 2009.

Procedures for investigations of Cuts, Welts and Bruises should be amended to provide that when suspicious bruising is reported (indicative of fingerprints, implements or otherwise suspect based on developmental age of child or location of bruise), and the investigator does not see the bruise, the reporter must be contacted prior to an initial safety CERAP determination (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 3).

FY 07 Department Update: The Office of Child and Family Policy has forwarded the final draft of Procedures 300 to the Division of Child Protection. The Procedures 300 workgroup is reviewing the final draft and expects completion by December 2007.

FY 08 Department Update: Allegation 11 was amended to address this recommendation.

DCFS Procedure 300 should be amended to provide that the decision to take protective custody of a child whose parent is receiving services from the Department (e.g., intact family, independent living, or residential programs) must include consideration of the degree of the parent's cooperation with services and the extent to which services provided address the allegation (from OIG FY 04 Annual Report, Death and Serious Injury 19).

FY 04 Department Response: The CERAP Advisory Council is currently reviewing the CERAP Protocol. The OIG recommendations will be shared with the group at their next meeting, January 2005.

FY 05 Department Update: Procedure 300.80 has been revised and the draft includes this consideration. Legal is currently reviewing Procedures 300 and it is projected all related tasks will be complete by Spring 2006.

FY 06 Department Update: The Division of Child Protection Committee has not completed its review and final revisions to Procedures 300. Once completed, these will be returned to the Office of Child and Family Policy to begin the process of approval from JCAR. Implementation date: Spring 2007.

FY 07 Department Update: The Office of Child and Family Policy has forwarded the final draft of Procedures 300 to the Division of Child Protection. The Procedures 300 workgroup is reviewing the final draft and expects completion by December 2007.

FY 08 Department Update: The internal and external review of Procedures 300 has been completed and comments were forwarded to the Associate Deputy for review. The revisions to Procedures 300 are expected to be finalized by January 2009.

The Department's Medical Director should consult with local experts on child abuse about the prompting questions regarding what, when, and how the information should be shared when seeking an opinion from a doctor about physical injuries. Procedures 300 should be updated to include this information (from OIG FY 06 Annual Report, Death and Serious Injury 6).

FY 07 Department Response: The Department will develop the guidelines.

FY 08 Department Update: Prompting questions for doctors were developed by the OIG and the Department and were communicated to the field as part of the Error Reduction Team Training. Allegation 11 was also amended to address this recommendation.

Once developed, all child protection investigators, supervisors, and managers should be trained on the investigation prompting questions discussed above (from OIG FY 06 Annual Report, Death and Serious Injury 6).

FY 06 Department Response: The Department agrees. The Office of Training will incorporate the guidelines into the CORE Training when they are complete. Target completion date: September 2007.

FY 07 Department Update: The Department agrees. The Office of Training will incorporate the guidelines into the CORE Training when they are complete.

FY 08 Department Update: Prompting questions for doctors were developed by the OIG and the Department and were communicated to the field as part of the Error Reduction Team Training.

The body chart used in child protection investigations should be corrected to reflect current research on the dating of children's bruises. This information must be conveyed via training, including supervisor training (from OIG FY 06 Annual Report, Death and Serious Injury 6).

FY 06 Department Response: The Department agrees. Procedure 300 is under revision and this information will be included in the revisions. Training will follow completion of Procedure 300.

FY 07 Department Update: Child & Family Policy has forwarded the final draft of Procedure 300 to the Division of Child Protection. The Procedure 300 Workgroup is reviewing the final draft and will be completed by December 15, 2007. Training will follow completion of Procedure 300.

FY 08 Department Update: The use of the Body Chart and changes on the allegation of bruises were completed in the curriculum and included in the training of staff and supervisors effective September 30, 2007. The changes in Procedures 300 were made by the Procedures 300 workgroup and released as part of Policy Transmittal 2008.18, dated August 7, 2008. This policy document has been incorporated in training staff and supervisors in the Error Reduction Team Training.

The Department's Procedural Guidelines for Investigation of Paramour Involved Families ("Paramour Policy") should be amended to include a determination of whether the paramour has any other children not living in the household and specifics about where and with whom they reside (from OIG FY 06 Annual Report, Death and Serious Injury 3).

FY 06 Department Response: The Department agrees. The Department will revise its policy to reflect changes in Paramour Policy (Procedures 300, Appendix H) regarding paramours' children.

FY 07 Department Update: Child Protection is currently revising the Paramour Policy and will send the draft to Child & Family Policy.

FY 08 Department Update: The current CERAP draft addresses this recommendation.

The Child Endangerment Risk Assessment Protocol (CERAP) should be amended to require that workers note when a risk factor cannot be answered because of insufficient information. Under such circumstances, workers should be required to perform diligent inquiry into relevant facts for assessment within 48 hours. The Department should develop tight procedures to ensure that there is follow-up and resolution of unknown variables (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 9).

FY 07 Department Update: The draft CERAP, currently being piloted, addresses this recommendation.

FY 08 Department Update: The recommendations resulting from the pilot were submitted to the Safety workgroup which is meeting regularly to incorporate these recommendations. There is a possibility of some additional slight modifications to incorporate the recent Department focus on Trauma-Informed practices. Procedures 300, Appendix G: Safety Assessment Enhancement, has been revised and will be implemented when changes to SACWIS are completed. The anticipated date of implementation is July 2009.

CONTRACT MONITORING

The new Contract Monitoring Protocol should include toxicology contracts. Toxicology contract monitoring should include a specific provision requiring review of Approval Forms and incorporation of guidelines developed by Service Interventions (from the OIG FY 07 Annual Report, General Investigation 1).

FY 07 Department Response: The Department agrees.

FY 08 Department Update: The new Contract Monitoring Protocol includes toxicology contracts.

The Department should develop an electronic system for tracking and linking toxicology resource approvals, caseworker sign-offs on service delivery and billing reviews (from the OIG FY 07 Annual Report, General Investigation 1).

FY 07 Department Response: The Department has developed an electronic tracking process for drops and their results. The contract administration unit has not been introduced to this process yet.

FY 08 Department Update: The Department is continuing to implement this recommendation.

The Department should have a written policy, developed by the Service Intervention Division, dictating the requirements for drug and alcohol drops. The policy and subsequent training should specify red flags that the Contract Liaison should look for in reviewing the Billing Summaries (from the OIG FY 07 Annual Report, General Investigation 1).

FY 07 Department Response: The Department has a work group to update the program plan and protocol for all toxicology providers. An inter-division work group, including Office of the Inspector General staff has been convened to address drug testing issues. The work group is developing standards for client drug testing, frequency and duration of testing, drugs to be included in test panels, program plan requirements for drug testing contractors, review criteria for contract monitors, use of breathalyzers to test for alcohol, and use of confirmation tests on positive urine screens. The group is planning to complete its recommendation in the fourth quarter of FY2008.

FY 08 Department Update: The finalization of the program is under review by the Service Intervention Division. The new program will be added to the FY 2010 contracts.

Drug and alcohol toxicology contracts should be competitively bid (from the OIG FY 07 Annual Report, General Investigation 1).

FY 07 Department Response: The Department agrees. This will be implemented with FY 2009 contracts.

FY 08 Department Update: Due to the program plan and protocol changes, this service was not bid in FY 2009. It is anticipated that the service will be out for bid in FY 2010.

The Department must immediately ensure that no further advance payments are issued without procurement of a surety bond and without signed verification that the expected billings and proposed budget will support timely repayment of the advance. Contract monitors must ensure that contractors are not incurring needless expenditures, such as the rental payments that the new agency incurred (from OIG FY 06 Annual Report, General Investigations 13).

FY 06 Department Response: The Division of Budget and Finance will work with the Office of Legal Services to develop an appropriate protocol for implementing a surety bond process as it relates to advance payments for non-board contracts.

FY 07 Department Update: Protocol development is in process. Anticipated completion date: May 2008

FY 08 Department Update: Boilerplate language was modified for FY09 contracts to include language specific to refunding excess revenues with timelines for a) termination of an agreement and b) end of contract year. A surety bond is not required since statutory language removing a conflict between the Child and Family Act and the State Finance Act has not been resolved. It was suggested to try to amend the Child and Family Act to bring it up to date with the law recognized by the comptroller and that has not been accomplished.

FY O8 OIG Response: Absent a legislative change, the Department must comply with current law and procure surety bonds. In addition, contract liaisons need to determine that budget and billings will support payback.

The Department must separately track all advance payments and ensure they are repaid in a timely manner (from OIG FY 06 Annual Report, General Investigations 13).

FY 06 Department Response: The Department's Office of Contract Administration and Office of Financial Management will work together to develop a separate tracking mechanism for advances made with non-board contracts. Estimated date of completion is February 28, 2007.

FY 07 Department Update: The tracking mechanism is under development. Anticipated completion date: May 2008.

FY 08 Department Update: The system development project was stopped prior to implementation and has not been completed. The practice of making advances was changed to provide advances in very few situations and then only for no more than two months; more of these types of contracts were changed to grants; the program plan was modified to include a reconciliation to recover the advances in the last two months and/or lapse period. The excess revenue audit

process also lowered the threshold for audit review in order to identify and recover advances if not captured in the program plan/reconciliation process.

FY 08 OIG Response: The Department should track even the few advance payments it currently makes, whether through grants or contracts.

The Department must develop a reliable Contract Monitoring process that would provide checks and balances and separation of functions to prevent the abuses identified in this Report. The process must include:

- **Quarterly review of expenditures to ensure that expenditures were related to the Contract**;
- **Quarterly review of services, to ensure that the goods or services were provided;**
- **Contractual and Rule requirement that any contractual spending for services or items not specifically covered under the Contract must be approved, in writing, by the Contract Division;**
- **Lapsed funds and obligation of funds must be approved in writing by the Contract Division.**

The Department must develop specific guidelines for disbursement when Fiscal Agents are used. The guidelines must include checks and balances to ensure that Fiscal Agents ascertain that the services or goods for which they issue checks have been provided. The use of Fiscal Agents must also be monitored by the Contracts division to ensure separation of functions. Fiscal Agents must understand that their role is not limited to check-writing and that they maintain fiduciary responsibility for expenditure of public funds.

The Department needs to systematically track public monies spent by contractors through subcontracts. The Department must be able to track who is ultimately responsible for providing services and who is ultimately receiving DCFS funds, in order to guard against conflicts of interest and double-billing.

The Department must develop a conflict of interest protocol, whereby entities are identified that the Department should not be contracting with, because of conflicts of interest, and the Department must purchase anti-conflict software that would identify Department funds expended on prohibited entities, similar to the practice at law firms (from OIG FY 06 Annual Report, General Investigation 12).

FY 06 Department Update: The Department is developing a workgroup that will consist of Contract Administration staff, Budget and Finance staff, and a representative(s) of the Conflict of Interest Committee to analyze the current processes and make recommendations to the Director for changes/enhancements.

FY 07 Department Update: Workgroup is being developed. Anticipated completion date: May 2008.

FY 07 OIG Response: These recommendations were made after the Inspector General's Office discovered that a quarter of a million dollars of Department funds intended to assist children and families was diverted into the private bank account of a Department manager. These recommended changes are critical to ensuring that such abuse of trust does not occur in the future. The Department has had over two years to institute these basic changes.

FY 08 Department Update: The workgroup is reviewing the monitoring and disbursement processes and will provide recommendations for revisions/changes to Executive Staff by March 2009. It is anticipated that execution of approved recommendations will be prior to finalization of the fiscal year 2010 contracts. The ability to purchase and/or implement software is dependent on available funding.

ETHICS

A task group should be assembled to revise Rule 437 and draft related Procedures (from OIG FY 07 Annual Report, Employee Conflict of Interest).

FY 07 Department Response: A task group was assembled, but is currently in abeyance and the Director is currently reviewing possible changes to Rule 437.

FY 08 Department Update: The conflict of interest workgroup has been reconvened and is in the process of finalizing the proposed changes to Rule 437 and in drafting new procedures that support the revised rule. The anticipated completion of revised Rule 437 is March 2009.

Procedural additions should include:

a. **If an employee takes secondary employment where there is the potential for contact with DCFS clients, a wall needs to be built between the DCFS employee and any DCFS clients being serviced by the secondary employer. In this case, the employee's supervisor should call the secondary employer to verify the wall is in place.**
b. **The supervisor should review secondary employment at the time of the annual review to see if a conflict has developed that was not present when the employee accepted the employment.**
c. **Instructions on how to contact the Conflict of Interest Committee.**
All DCFS employees should receive training on the revised Rule and Procedures 437 (from OIG FY 07 Annual Report, Employee Conflict of Interest).

FY 07 Department Response: The Director is currently reviewing possible changes to Rule 437.

FY 08 Department Update: The Department has reconvened and is in the process of finalizing the proposed changes to Rule 437 and in drafting new procedures that support the revised rule. The anticipated completion of revised Rule 437 is March 2009.

The task group should consider the extent to which private agencies should be included in Rule 437 (from OIG FY 07 Annual Report, Employee Conflict of Interest).

FY 07 Department Response: The work group is currently in abeyance and the Director is considering the extent to which private agencies should be included in Rule 437, Employee Conflict of Interest. The work group was provided with redacted copies of certain Office of the Inspector General reports.

FY 08 Department Update: The conflict of interest workgroup has been reconvened and is in the process of finalizing the proposed changes to Rule 437 and in drafting new procedures that support the revised rule. The anticipated completion of revised Rule 437 is March 2009.

The Department should incorporate into its training and Employee Manual the qualification that in order to trigger the ex parte communication reporting requirements for pending rulemaking, the employee should reasonably believe that the contractor is intending to influence the rulemaking process (from OIG FY 06 Annual Report, General Investigations 27).

FY 06 Department Response: Revisions have been approved for inclusion in the next revision of the Employee Handbook. Anticipated time frame: December 2006.

FY 07 Department Update: This information will be included in the next revisions of the Employee Handbook. Target completion date: June 2008.

FY 08 Department Update: The information was included in the Employee Handbook and employees were notified via a D-Net announcement on December 4, 2007.

FOSTER HOME LICENSING

Procedure 383, Licensing Enforcement must be revised to address the deficiencies in notification and completion of licensing investigations of licensed foster homes. In 2004, the Inspector General recommended and the Department agreed to have Quality Assurance conduct a review of Central Office of Licensure's method of identifying CANTS reports on licensed foster homes and establishing a schedule of reliability checks for the system of identifying foster homes with a CANTS report (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 2).

FY 07 Department Response: Final revision of Rule 383 was submitted for approval. JCAR process has not been completed and the Director's office wants to review further.

FY 08 Department Update: Rule 383, Licensing Enforcement, was adopted effective March 17, 2008. Procedures 383 were released for public comment in August 2008, which included the revised provisions for licensing investigations.

Rule 383 has been in draft form for over a year. The Department should prioritize finalizing the promulgation of this important rule (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 2).

FY 07 Department Response: Final revision of Rule 383 was submitted for approval. Notice of Adoption of the rule will be filed when draft is approved.

FY 08 Department Update: Rule 383 was adopted effective March 17, 2008.

The Department's licensing standards should require a reassessment of a foster home license when the licensing agency becomes aware of a major change in the family composition, such as a spouse/paramour moving out of the home. The reassessment should include a review of the foster parent's capability to care for the children in light of the loss of a second caretaker as well as the circumstances surrounding the change and any ensuing custody or other legal disputes (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 2).

FY 08 Department Update: Appropriate revisions have been sent to the Office of Family and Child Policy.

The Department should develop guidelines for shared monitoring responsibilities when a single foster home has children monitored by different agencies or when the case monitoring and license monitoring functions are split between agencies. The guidelines should include the following requirements:

- **a staffing of all involved case and licensing workers;**
- **written agreement of roles and responsibilities of each worker;**
- **written guidelines concerning the responsibility to share information and the process for sharing information (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 2).**

FY 08 Department Update: The Department is continuing to review this recommendation.

The Department should issue a policy memorandum that states that whenever possible, each foster home should have a single entity that monitors placement of foster children and foster home licensing. POS may grant waivers to the policy based on individual children's needs but must ensure that the guidelines stated above are in place whenever a waiver is granted (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 2).

FY 08 Department Update: The Department is continuing to review this recommendation.

Whenever a waiver is granted, and case responsibility is transferred to a single agency, the relinquishing agency should not be penalized, but should be moved up for case rotation assignment of a new case (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 2).

FY 08 Department Update: The Department is continuing to review this recommendation.

DCFS licensing enforcement procedures must provide for immediate licensing revocation proceedings with findings of egregious licensing violations (from OIG FY 04 Annual Report, General Investigation 1).

FY 07 Department Update: Final revision of Rule 383 was submitted for approval. The Joint Committee on Administrative Rules process has not been completed. The Director's Office will review further. Target date for completion: March 2008.

FY 08 Department Update: Rule 383, Licensing Enforcement was adopted effective March 17, 2008.

The Department should immediately issue a policy clarification for Rule 402.15 regarding the number and ages of children permitted in licensed foster homes. The clarification memo should emphasize that all children receiving full time care in the home - birth, adopted, foster and otherwise - are to be figured in to the total (from OIG FY 06 Annual Report, Death and Serious Injury 8).

FY 07 Department Update: Draft has been revised and will be submitted to licensing for review by November 15, 2007. Target completion date: January 2008

FY 08 Department Update: The draft policy is being revised. The estimated date of completion is June 2009.

GENERAL

The Department's legislative liaison should pursue legislative amendment to Illinois Statute 430 ILCS 65/4-65/10 Public Safety to address the need to revoke firearm registration of parents who demonstrate an inability to keep their firearms from minors under a set of conditions that include: minors, age 16 and under, with a mental condition or behavior that poses clear and present danger to self or other persons (e.g., discharging firearms in the absence of parental supervision, shooting guns at other persons, taking weapons or ammunition to school) (from OIG FY 07 Annual Report, General Investigation 3).

FY 07 Department Response: The Department believes that any legislation to amend Illinois Statute 430 ILCS 66/4-65/10 should be negotiated by the Illinois State Police and the Department of Natural Resources. The Department of Children and Family Services has no involvement in firearms law.

FY 07 OIG Response: The OIG is pursuing the legislative change.

FY 08 OIG Update: House Bill-5191, which would amend the Firearm Owners Identification Card Act, was introduced to the Illinois General Assembly by State Representative Greg Harris. Through a collaborative effort by the OIG and Representative Harris, the House passed the Bill on April 30, 2008. On May 1, 2008 the Bill arrived in the Senate and is being sponsored by State Senator Heather Steans. The Bill is currently pending in the Senate.

The anticipated training for graduated sanctions for child welfare workers should include more detailed court training (how to testify, how to screen, overlapping court involvement, court orders) (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 9).

FY 07 Department Response: The Department agrees. The Office of Training will work with DPO to develop a more detailed court training curriculum. The training will be delivered beginning November 2008 to DCFS and POS child welfare workers.

FY 08 Department Update: The Office of Training had problems with the vignettes that were prepared with the assistance of a university. This product will be revised and completed June 2009 and training will begin in July 2009.

The SACWIS system should be modified so that the system has the necessary data to be capable of (1) identifying foster parents when their name is entered into the 'Person Search' option and (2) notifying a foster care licensing agency when the State Central Register receives a report on a foster parent or foster home. Although this report does not involve identification of private agency employees, modification of the SACWIS system should include identification of private agency employees because of the DuPuy federal lawsuit (from OIG FY 06 Annual Report, Death and Serious Injury Investigation 4).

FY 06 Department Response: It has been determined that the recommendation requires implementation of the Licensing and Resource systems which was scheduled for Phase III of SACWIS. Phase III is currently on hold due to a lack of available resources.

FY 07 Department Update: It has been determined that the recommendation requires implementation of the Licensing and Resource systems which was scheduled for Phase III of SACWIS. Phase III is currently on hold due to a lack of available DCFS resources and funding.

FY 07 OIG Response: This recommendation was made after a ward of the Department was killed in a foster home that had been recently investigated for physical abuse. The foster care agency was unaware of the prior investigation because the prior investigation had involved the biological son of the foster mother's paramour. The Department had not known at the time that the woman was a foster parent and the other child in the home was a ward. The OIG reiterates the importance of making this minor change to the SACWIS system that could increase child safety.

FY 08 Department Update: The modification was implemented on August 28, 2008 and the changes were included in the most recent SACWIS Release 3.3.

The OIG recommended that Rule 412 be revised:

- **To permit the Department to refuse to issue a license with knowledge that the applicant had committed a violation that would warrant revocation or if the applicant had engaged in behavior that would pose a risk to children or state resources;**
- **To expand the list of criminal pending charges or convictions that would warrant a refusal to issue to include any crime of which dishonesty is an essential element;**
- **To permit the Department to refuse to issue a license if the applicant provides false information during the licensing process;**
- **To provide guidelines for assessing criminal convictions and abuse or neglect findings that are not bars to licensure;**
- **To permit the Division of Child Welfare Employee Licensure to refer applications for investigation to verify facts presented (from OIG FY 06 Annual Report, General Investigations 26).**

FY 07 Department Update: The Clinical Division, through the Child Welfare Employee Licensure (CWEL) staff, has drafted proposed changes to Rule, Part 412. The draft of the proposed amendment incorporates input from the OIG, and the appointed Board members of the Child Welfare Employee Licensure (CWEL) program. The text of the proposed amendment will be submitted to the Director for review, approval, and transmittal to the Joint Committee on Administrative Rules (JCAR).

FY 08 Department Update: The revisions to Rule 412 were submitted to the Office of Child and Family Policy on November 21, 2008 and will begin the revision/comment process. The anticipated date of completion is June 2009.

The Department's Conflict of Interest Committee should establish procedures for building walls between private agencies and DCFS Administrators who have decision-making power over agencies that they previously worked for (from OIG FY 06 Annual Report, General Investigations 28).

FY 06 Department Response: The procedures have been drafted by the Conflicts of Interest Committee.

FY 07 Department Update: The Director is considering the recommended changes.

FY 08 Department Update: A conflict of interest workgroup is in the process of finalizing the proposed changes to Rule 437 and is drafting new procedures that support the revised rule. The anticipated date of completion is March 2009.

When literacy is a problem, caseworkers should make referrals to appropriate literacy intervention programs, preferably family literacy programs. Services and treatment providers should be informed when an individual's literacy problem poses an obstacle to effective interventions (from OIG FY 06 Annual Report, Death and Serious Injury 5).

FY 07 Department Update: This is being included in the revised intake and placement curriculum, which is still in development. The anticipated date of completion is December 2007.

FY 08 Department Update: The practice of identifying adult literacy issues and making service referrals to adult literacy programs was added to the Child Protection Foundation training program in October 2008.

MEDICAL

The Department's Guardianship Administrator should identify and review all wards who have a current diagnosis of Reactive Attachment Disorder and develop and implement a plan to determine whether these children and youth were properly diagnosed and are receiving appropriate treatment or whether they require an evaluation that follows recommended guidelines of the American Academy of Child and Adolescent Psychiatry, and the American Professional Society on the Abuse of Children. The OIG will provide the Guardianship Administrator with the two investigations where RAD was misused (OIG FY 07 Annual Report, General Investigations 2).

FY 07 Department Response: The Department's Clinical Division will review all wards with a current diagnosis of Reactive Attachment Disorder.

FY 08 Department Update: Using the guidelines and standards proposed by the American Academy of Child and Adolescent Psychiatry, the Department's Chief Consulting Psychologist, will identify all children in placement who have a diagnosis of RAD. A random clinical review of at least five children will be completed to ensure proper assessment, diagnosis and treatment. In addition, a letter delineating the American Academy's standards and guidelines for the assessment and treatment of RAD will be drafted and distributed to all therapy and counseling providers. This should be completed by the end of February 2009.

The OIG and the Department should continue their collaboration in developing a document for medically complex children prior to finalizing proposed Procedures 300, Appendix L, which contains investigation and case management guidelines and procedures for investigating certain allegations (OIG FY 07 Annual Report, Children with Medically Complex Conditions).

FY 07 Department Response: Additional input is being received regarding children with special healthcare needs. Recommendations from this group will be shared with the Clinical Division of Child & Family Policy.

FY 08 Department Update: The workgroup revising Procedures 300 abandoned the separate Appendix L, and incorporated the content regarding medically complex children in the body of Procedures 300.370 (J), 302.388, and 300.80. The revisions to Procedures 300 were published and are being reviewed by DCP for final publication. An amendment to Rule 300, Allegation 79 also addresses children with complex medical needs. The amendment to the rule was posted on the D-net and the Web Resource for review and comment.

The Guardianship Administrator's Office should regularly obtain information from Medicaid Prescription Use Screens to better service wards who are prescribed multiple medications (from OIG FY 06 Annual Report, General Investigations 4).

FY 06 Department Response: The Department's consulting psychiatrist has been in discussions with staff from DHS, regarding linking the DCFS Psychotropic Medication Consultation Program database and the IDPA Medication Screens to provide more timely access to Medicaid Payment Data.

FY 07 Department Update: DHS General Counsel is working to secure approval. After approval is secured, DCFS Legal will work to secure the signatures required to implement the Intergovernmental Agreement. Anticipated completion date: May 2008.

FY 07 OIG Response: The Intergovernmental Agreement addresses only access to records of psychotropic medication and only for wards that the Department is unable to locate. This does not address the recommendation, which was to monitor multiple medications of all wards. It should not be limited to wards that cannot be found, and it should not be limited to psychotropic medications, since non-psychotropic medications can be counter-indicated for use with psychotropic medications.

FY 08 Department Update: DCFS is working with the Department of Healthcare and Family Services to obtain access to the Medicaid prescription use screens. The anticipated date of completion is January 2009.

The Department nursing staff, when asked to consult on a medically complex child, should conference with other medical professionals as part of the consultation and ensure the caseworker has established communication with the medical professionals involved in the child's care (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 10).

FY 07 Department Update: Child & Family Policy has formatted the final draft version of Children with Special Health Care Needs - Draft Appendix L and Procedures 302, Subsection 302.388(f)(10). A D-Net announcement will announce the 800 number for nursing referrals statewide once the number is activated.

FY 08 Department Update: Department procedures for dealing with children with Special Health Care Needs were outlined in Policy Transmittal 2008.09 effective May 16, 2008 and amended the following policy documents: Procedures 300.70, 300.80 and 302.388.

The Department should require intact family caseworkers to meet with treating medical professionals when a child in the family has a chronic medical condition (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 10).

FY 07 Department Update: Child & Family Policy has formatted the final draft version of Children with Special Health Care Needs - Draft Appendix L and Procedures 302, Subsection 302.388(f)(10). A D-Net announcement will announce the 800 number for nursing referrals statewide once the number is activated.

FY 08 Department Update: Department procedures for dealing with children with Special Health Care Needs were outlined in Policy Transmittal 2008.09 effective May 16, 2008 and amended the following policy documents: Procedures 300.70, 300.80 and 302.388.

The Department, as recommended in a previous report, should apply a targeted feeding assessment, such as the Nursing Child Assessment Satellite Training, in cases with allegations of inadequate food and/or malnutrition and failure to thrive and where there are chronically ill children whose feeding regimen may require occupational therapy adaptations (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 10).

FY 07 Department Update: Comments are being incorporated into the draft procedures for medically complex, including children with feeding problems.

FY 08 Update: The draft procedures are comprehensive, but do not specifically address feeding issues. The OIG will share research and targeted feeding assessment information with the DCFS Chief of Nursing Services.

Because of the increased complexity of technology-dependent children, the Department's protocol for investigations of medically complex cases must include a standard of investigation that addresses:

- **Situations where the reporter of the hotline call is a home health professional working in the family's home. Because multiple parties are involved in the child's care in the home, and in an effort to minimize bias possibly rooted in relationship conflict, the child protection staff should be expected to get an independent medical evaluation to help determine abuse or neglect. It is necessary to have an expert opinion outside of the opinion and evaluation of the family's nursing agency in order to minimize bias possibly rooted in relationship conflict. The independent medical assessment should take into account the comparative risks and benefits of home care and out-of-home care for each child under the circumstances of each case.**

- **Child protection staff investigating families involving children with a Home Waiver should make it standard practice to (1) identify the family's UIC Division of Specialized Care for Children (DSCC) Care Coordinator as a primary source of historical and current information regarding the child, family, the child's care, the home environment, the parents' relationship with health care professionals, and (2) request the DSCC Guidelines to understand the parent-service provider relationship, including role boundaries and parental rights (from OIG FY 05 Annual Report, General Investigation 13).**

FY 07 Department Update: Child & Family Policy has formatted the final draft version of Children with Special Health Care Needs - Draft Appendix L and Procedures 302, Subsection

302.388(f)(10). A D-Net announcement will announce the 800 number for nursing referrals statewide once the number is activated.

FY 08 Department Update: The Department's procedure for dealing with children with Special Health Care Needs was outlined in Policy Transmittal 2008.09, effective May 16, 2008 and amended the following policy documents, Procedures 300.70, 300.80 and 302.388. Procedures 302, Appendix O defined referral for Nursing Consultation Services and the CFS 531, DCFS Nurse Referral Form was introduced.

PERSONNEL

The Department should develop policy to address suspected substance abuse in the workplace (from OIG Recommendations made in 05, 01 and 99).

FY06 Department Response: The Department developed a definition and procedure for Reasonable Suspicion testing. The Department agrees to amend the Employee Manual and the Employee Licensure Rule to address Reasonable Suspicion of substance abuse and will also engage in discussions with the union.

FY 07 Department Update: The Department's workgroup addressing the need for incident-based reasonable suspicion drug or alcohol testing is currently developing protocol for pre-employment drug testing. Reasonable suspicion testing has been put on hold temporarily.

FY 08 Department Update: The Department began pre-employment testing in February 2008, but has had to suspend this program due to budgetary cuts. The Department plans to re-implement this program as soon as it is fiscally feasible. Reasonable suspicion testing will be negotiated between management and the Union in the future.

FY 08 OIG Response: The OIG has been continuously recommending this critical change in policy for nine years. The policy change sought by the OIG would have a minimal budgetary impact. The lack of reasonable suspicion policy, which would allow for testing when an employee is reasonably suspected of being under the influence of drugs or alcohol, continues to place our children, families and staff at risk.

The Department's Division of Legal Services should review the Office of Employee Records and Payroll's current practices of responding to employee reference checks (from OIG FY 06 Annual Report, General Investigations 15).

FY 07 Department Update: The checklist is currently under review by Legal who will consult with Central Management Services. Target completion date: March 2008.

FY 08 Department Update: The procedure used in DCFS Employee Services and Payroll to respond to employment verification requests appears to be appropriate.

SERVICES

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

the developmentally delayed population for community linkage and additional case management services (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 8).

FY 07 Department Response: The revisions to 302.388 have been requested.

FY 08 Department Update: The draft Procedure 302.388 was forwarded to the Office of Child and Family Policy on September 25, 2008. The Office of Child and Family Policy is now in the revision and comment process. The anticipated date of completion is June 2009.

The Department should amend Procedures 302.388 Intact Family Services to provide that children and parents with epilepsy are referred to the Epilepsy Foundation for education, case management and assistive resources (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 8).

FY 07 Department Response: The revisions to 302.388 have been requested.

FY 08 Department Update: The Nursing Consultation Services Policy Transmittal 2008.09 was released in hard copy on June 16, 2008 and published on the D-net on June 28, 2008.

The Department's Division of Clinical Practice should develop training and resources for working with caregivers with developmental disabilities to be included in the Department's core training curriculum (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 8).

FY 07 Department Response: The content of the training is developed and will be converted into web-based training. It will be included in the pre-service training for all job specialties and caregivers.

FY 08 Department Update: The online course was completed as planned in FY 2008, effective February 25, 2008. The online course is incorporated in pre-service and in-service training for foster and adoptive caregivers.

The Department's Division of Clinical Practice should assist child protection and case management staff in managing cases involving caregivers with a developmental disability (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 8).

FY 07 Department Response: The content of the training is developed and will be converted into web-based training. It will be included in the pre-service training for all job specialties and caregivers. Anticipate completion date: December 2007.

FY 08 Department Update: The on-line course was completed and effective February 25, 2008. The on-line course is incorporated in pre-service Foundation training for all new direct service child protection and child welfare staff and supervisors. The on-line course is open for registration to all veteran child protection and child welfare staff for in-service training. The DD Administrator convened a tele-conference meeting with Cook DCP Administrators to discuss the need for a statewide centralized consultation process with DCP investigators and staff. The discussion identified necessary and practical information regarding developmental disabilities that could be used with staff, advising them of when to seek immediate consultation from the DD Administrator. The training on this information is scheduled for March 2009.

The Department should train Child Protection and Intact Family staff on utilization of the Social Security Administration's consent for release of information to obtain information on a parent or child's qualifying disability (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 8).

FY 07 Department Response: This is included in the on-line orientation training. Confidentiality and release of information is currently covered in training for all staff and will be included in the revised Foundations, which will be ready for delivery in December 2007.

FY 07 OIG Response: The orientation training does not include training on securing consent to access relevant social security disability information.

FY 08 Department Update: The material is not covered in Foundation training for child protection and child welfare staff. The OIG will work with the Department to ensure that this material will be included in the Foundation training.

The Department should amend Procedures 302.388 Intact Family Services to provide that when a parent has a condition that may become debilitating, Intact Family Services staff ensure that the parent has a back-up caregiver plan that meets the child's medical, developmental and scholastic needs (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 8).

FY 07 Department Response: The revisions to 302.388 have been requested.

FY 08 Department Update: Draft Procedure 302.388 was forwarded to the Office of Child and Family Policy (OCFP) on September 25, 2008. The OCFP is now in the revision and comment process. The anticipated date of completion is June 2009.

The Department should immediately implement practice changes suggested by the Family Matters Pilot Program including: a) expand post adoption services to provide additional assistance to families in which an adoptive parent or legal guardian dies; b) develop written information about how to implement an identified back-up plan; c) develop resources to complete home studies and interim studies for children in subsidized guardianship, or adoption to subsidized guardianship conversion situations (OIG FY 07 Annual Report, Initiatives, Trainings, and Collaborations Involving Older Caregivers).

FY 07 Department Response: The Department agrees.

FY 08 Department Update: The Department has convened an advisory group that meets quarterly to promote consistency on older caregiver programs and issues.

A representative from Training should regularly update all *Family Matters* and *Kids and Older Caregiver's* training content to promote consistency and incorporate new material into regular training curricula (from the OIG FY 07 Annual Report, Older Caregivers Addendum).

See above Response and Update.

When an officer of the court receives *Family Matters* or *Kids and Older Caregiver*'s training, DCFS Legal should be present to ensure consistent information and coordinated service delivery (from the OIG FY 07 Annual Report, Older Caregivers Addendum).

See above Response and Update.

Training should develop guidelines to ensure that all information given to older caregivers, including information related to financial and health care planning, is consistent with material from Bureau of Elder Rights and the National Adult Protective Services Association (from the OIG FY 07 Annual Report, Older Caregivers Addendum).

See above Response and Update.

The Subsidized Guardianship Agreement (CFS 1800) should be amended. At a minimum this agreement should allow for payment suspension and termination of the agreement when custody of a minor is restored to a biological parent. In the interest of complete and full disclosure however, the possibility of a child returning to his/her biological parent and the steps necessary for that to occur should be clearly identified in the General Provisions Section of the Agreement (from the OIG FY 07 Annual Report, Older Caregivers Addendum).

FY 07 Department Response: The Department agrees.

FY 08 Department Update: The Department is continuing to review implementation of the recommendation.

In any case in which a change in guardianship essentially represents a return home, DCFS Legal should be involved to ensure that the appropriate petition is filed in the appropriate court and to represent the Department at any subsequent hearing on the matter (from the OIG FY 07 Annual Report, Older Caregivers Addendum).

FY 07 Department Response: The Department agrees.

FY 08 Department Update: The Department is continuing to review implementation of the recommendation.

The Department must monitor and enforce contract compliance of POS agencies with Department contracts to acknowledge and include fathers and paternal family members as an integral part of case management services. Department monitors must ensure that Department Procedures 302: Services Delivered by the Department and its Appendix J: Pregnant and/or Parenting Program is followed (OIG FY 07 Annual Report, General Investigation 22).

FY 07 Department Response: The Department agrees. A memorandum is being drafted to DCFS and POS staff. Target completion date: December 2007.

FY 08 Department Update: The newly appointed Deputy for Monitoring is reviewing this recommendation and will address this issue by February 2009.

The Department should review and update the Emergency Reception Center Manual to include expectations of follow-up workers bringing children to the Emergency Reception Center (from OIG FY 06 Annual Report, General Investigations 4).

FY 07 Department Update: The Updated ERC Protocol/Manual (Transmittal) has not been finalized and is on hold with the Office of Child and Family Policy awaiting information resolution regarding shelter transportation issues. When it is completed the informational transmittals will go out to DCFS, POS, CWS, and DCP staff. Also training will take place for all staff regarding protocol on how CWS or DCP can make an Emergency Shelter referral and intake guidelines for bringing children and youth into ERC for an emergency temporary shelter care placement.

FY 08 Department Update: The ERC Protocol has been drafted and is awaiting approval to be sent out for comment. The anticipated date for distribution/implementation is January 2009.

To best meet the clinical needs of children and families, Intact Family Procedures should require a case conference be convened as part of the clinical provider's family assessment process to discuss treatment needs identified in the Department's Integrated Assessment. The case conference should include all service providers involved with the family and involved extended family members (from OIG FY 07 Annual Report, General Investigations 2).

FY 07 Department Response: The Practice and Procedural memo has been reviewed and revisions have been made. The memo is scheduled to be distributed to staff in December 2007.

FY 08 Department Update: A Practice and Procedural Memo was distributed to Child Protection staff on September 26, 2007.

When a child welfare worker has a pregnant mother on his/her caseload who has been previously indicated for abuse or neglect and refuses to give the child welfare worker information as to the due date and expected place of delivery and the worker has concerns about the new baby, the worker should increase visitation within 2 months around the anticipated due date, document attempts to get consent to speak with doctors, document contacts with family and support network to seek notification of birth (from OIG FY 07 Annual Report, Death and Serious Injury Investigation 7).

FY 07 Department Response: Procedure is currently being revised. Targeted completion date: June 2008.

FY 08 Department Update: The revisions are in process and the anticipated date of completion is February 2009.

Procedures 302 should be revised to show that certified copies of vital records will be assessed a fee and that the fee on administrative copies of vital records will be waived by the Department of Public Health, but not necessarily by the local county clerk. This procedure should also address the issue of prepaid postage (from OIG FY 07 Annual Report, Birth Certificates).

FY 07 Department Response: Language is being drafted that will be submitted to the Office of Child & Family Policy by December 2007.

FY 08 Department Update: Operations is currently revising Procedures 302. The anticipated date of completion is February 2009.

The Department should arrange a meeting with the Department of Public Health (DPH) and the Department of Public Aid to work out the difficulties in securing birth certificates by Department workers, POS agency workers and adoptive parents (from OIG FY 07 Annual Report, Birth Certificates).

FY 07 Department Response: A meeting with DPH is scheduled.

FY 08 Department Update: DPH wanted any policy that requires a copy of the birth certificate in the file. They only issue birth certificates for court and adoption. That is their position.

The Department should develop protocol for advising developmentally delayed clients of their rights (from OIG FY 07 Annual Report, General Investigations 4).

FY 07 Department Response: The Developmental Disabilities Administrator submitted a draft of the proposed protocol advising clients who have developmental disabilities of their rights to the Division of Clinical Services and Professional Development on November 1, 2007. The draft is currently being reviewed and revised. Targeted completion date: December 2007.

FY 08 Department Update: The Developmental Disabilities Administrator developed drafts of a developmental disabilities practice guide, a training outline, a protocol, and a notification of rights and responsibilities. Draft materials were provided to the OIG December 7, 2007. The DCP Protocol training material was under review in October and November 2007 and submitted. The developmental disabilities practice guide, training outline, protocol and notification of rights and responsibilities were resubmitted and approved in August of 2008.

The Department should develop a specialized intact family team with experience and expertise in working with developmentally disabled parents. In the alternative, the Department should provide intact family workers with training on working with parents with developmental delays (from OIG FY 07 Annual Report, General Investigations 4).

FY 07 Department Response: The web-based training on working with individuals with developmental disabilities is being developed by a university. Target completion date: December 2007.

FY 08 Department Update: The on-line course was completed and effective February 25, 2008. The on-line course is incorporated in pre-service and in-service training for Intact Family Services and Child Welfare staff.

The Department's Division of Legal Services should draft a standardized form for the appointment of Short-term Guardianship and provide training on proper use of the form (from OIG FY 07 Annual Report, General Investigations 4).

FY 07 Department Response: DCFS Legal has assigned an attorney to develop training on the appropriate use of the statutory Short-term Guardianship form.

FY 08 Department Update: The CFS 444-2: Appointment of Short-Term Guardian Form was added to the Department's website in December 2007, however the form needs to be amended to account for recent statutory changes.

The Department should develop an internal mechanism to notify the post-adoption payment unit upon the death of a minor adopted child (OIG FY 07 Annual Report, Death and Serious Injury Investigation 1).

FY 07 Department Response: The Office of Information Technology Services will have the additions completed by January 2008.

FY 08 Department Update: The Department is still in the process of implementing this recommendation.

Procedures for Child And Youth Investment Teams (CAYIT) should be amended to include situations in which a move is requested for any reason other than a ward's best interest (OIG FY 07 Annual Report, General Investigations 14).

FY 07 Department Response: The CAYIT Policy is currently under review. Target completion date: February 28, 2008.

FY 08 Department Update: CAYIT procedures (Policy Guide 2006.04) have been revised to clarify and differentiate the referral process for placement changes through CAYIT, Clinical Placement Staffing Review and Residential Transition Discharge Planning Protocol. The revised procedure will be sent to the Office of Child and Family Policy for review and then sent out for comment.

In split custody cases with a history of substance abuse and relapse, the Department should require random drug drops to assist the Department in securing necessary services for the children and family. In cases of alcoholism, random urine testing is not reliable. Breathalyzers are preferable. The OIG reiterates its prior recommendation that DCFS acquire breathalyzers and train on their use (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 21).

FY 07 Department Update: The Department has implemented new substance affected family policies that include drug testing requirements. Staff are being trained on the procedures as part of the Reunification training. An inter-division work group is developing additional guidelines for drug testing DCFS clients and monitoring DCFS drug testing contracts. The work group is developing standards for frequency and duration of drug testing, use of breathalyzers, and the panel of drugs for which to test. Anticipated completion date is the fourth quarter of FY-2008.

FY 08 Department Update: The recommendation is in progress and the anticipated date of completion is March 2009.

When a medical report indicates that a caregiver, regardless of age, may not be capable of caring for a child into adulthood, the back-up caregiver should sign a statement that he/she is aware of that fact and is still willing to serve as the back-up caregiver (from OIG FY 05 Annual Report, General Investigation 19).

FY 07 Department Update: Revisions to Rule 309 Adoption Services have been made by the Office of Child and Family Services and it is under review. Target completion date is March 2008.

FY 08 Department Update: The CFS 486, Adoption Conversion Assessment, section 16, addresses the backup caregiver issue.

FY 08 OIG Response: The CFS 486, Adoption Conversion Assessment, provides for discussion with a back-up caregiver, but it does not address the back-up caregiver's awareness of the caregiver's potential incapacity and need for signature reflecting that awareness and willingness to serve as the back-up caregiver.

The Department should revise Procedure 327, Guardianship Services, Appendix F – Immigration/Legalization Services for Children with Undocumented Status to reflect current practices. Because of the complexity and unfamiliar nature of immigration services to child welfare staff, the Department should develop a resource link on the D-Net to provide workers with a central location for obtaining needed information/instruction. There should be communication within the Department regarding the development of computerized/satellite training to reflect current practices of the Immigration Services Unit (from OIG FY 07 Annual Report, General Investigation 20).

FY 07 Department Response: Final draft of Procedure 327 Appendix F has been provided to the Inspector General's Office for review.

FY 08 Department Update: The final version of Procedures 327, Appendix F was issued on June 20, 2008. The virtual training which reflects the current practices of the Immigration Services Unit is now available on the D-net.

FY 08 OIG Response: Although some revisions to the Guardian & Advocacy Division on-line training were made, current procedural information has not been included. The revised Procedures 327, Appendix F: Immigration/Legalization Services for Foreign Born DCFS Wards has not replaced obsolete information provided through the links "Procedures for acquiring SIJS" and "Click here to review the [Immigration Services] Alert". The "SSN Application Procedures" link to Procedures 327, Appendix G: Application for Social Security Number is not applicable to wards applying for an SSN after acquiring Legal Permanent Resident status. The "SSN Application Procedures" link should direct users to P327, Appendix F, section (c)(7). In addition, links intended to direct users to Policy Guide 2008.02, Mexican Consulate Notification of Mexican or Mexican American Minors in the Custody of the Department are not functioning.

Timely identification of undocumented wards that may be eligible for status adjustment with the USCIS is necessary to ensure future service delivery and continued best interest. The Immigration Services Unit should re-implement the tracking process/data base for all referrals received and questions regarding a child's citizenship status should be added to the Client Service Plan (hard copy and SACWIS) as follows:

"Current Goal"
After "Child's Name:" add: "Is child a US Citizen? □ Yes □ No"
If yes, the worker can proceed to Reason for Goal.

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

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

(from OIG FY 07 Annual Report, General Investigation 20).

FY 07 Department Response: The Immigration Services Unit currently has a tracking database for all referrals received but it does not provide tickler alerts. The Inspector General's Office provided a database via disc, which they developed during their review of the Immigration Services Unit. The disc was provided to the Immigrations Services Coordinator and she will incorporate with the existing database. All referrals received are being entered into the database provided by the Inspector General's Office. The Immigration Alert was distributed in June 2005 on the D-Net. Adjustments have been made to SACWIS, which may be overly broad. The Deputy Director is reviewing with Legal Counsel and the Attorney General's Office.

FY 08 Department Update: The Immigration Services Unit staff continues to assist caseworkers in establishing contact with foreign consulates per Procedure 327, Appendix F.

Given that obtaining a child's birth certificate through a foreign consul/embassy is an unfamiliar process to most caseworkers, the Immigration Services Unit should expand its duties to assist caseworkers with this task regardless of the child's goal. Immigration Services Unit personnel have special knowledge of working with foreign consuls/embassies. Should the child's goal change from Return Home, the caseworker would have the necessary documentation to facilitate an SIJS petition (from OIG FY 07 Annual Report, General Investigation 20).

FY 07 Department Response: The Inspector General's Office is reviewing the draft of Procedures 327, Appendix F.

FY 08 Department Update: Immigration Services Unit staff continues to assist caseworkers in establishing contact with foreign consulates per Procedure 327, Appendix F.

TEEN PARENT SERVICE NETWORK

The Department should amend the HealthWorks contract to ensure that at the Initial Health Screenings, if a pregnancy is confirmed, an obstetrical ultrasound is performed to confirm that the pregnancy is in the uterus and to estimate the gestational age of the fetus, and that a health professional advises and counsels the youth regarding pregnancy options (OIG FY 07 Annual Report, General Investigation 22).

FY 07 Department Response: The Department will notify HealthWorks that a Comprehensive Health Evaluation (CHE) and ultrasound must be completed within 7 days when pregnancy is known or suspected. The Department will notify the HealthWorks Lead Agency for Cook County regarding completing a CHE for pregnant wards within 7 days and performing a pregnancy test during the CHE if pregnancy is suspected. Wards that are pregnant will be

referred to an OB/GYN, whose medical judgment will dictate the need for an ultrasound. Notification will be sent by November 2007.

FY 07 OIG Response: A pregnant youth who has not received prenatal care must receive an ultrasound within seven days of the confirmation of pregnancy.

FY 08 Department Update: A draft letter to HealthWorks will be sent to the DCFS Medical Director for review no later than December 4th. Once finalized, the letter will be sent to the HealthWorks Lead Agency.

The Teen Parenting Service Network's phone line should be used during regular business hours for child welfare workers to report a teen pregnancy as soon as it becomes known (OIG FY 07 Annual Report, General Investigation 22).

FY 07 Department Response: The change to the UIR will be added in the Appendix of Rule 331, which is currently being revised.

FY 08 Department Update: The revisions are in process. The anticipated date of completion is June 2009.

Currently, the Department's Unusual Incident Reporting Form (UIR) has a section – *Type of Incident Checklist* – that includes identification of parenting ward or discovery of a ward's pregnancy should be changed to more clearly communicate the minor's status (pregnant, parent, or both) (OIG FY 07 Annual Report, General Investigation 22).

FY 07 Department Response: The Department agrees to redraft the form.

FY 08 Department Update: The CFS 119, Unusual Incident Reporting Form was amended and effective December 2007.

DCFS Rule 315, Appendix A should be amended to require a CERAP be completed when a parent who has an open DCFS case and whose children have previously been removed from his or her care has another child. The Teen Parent Service Network Policies and Procedures should be likewise amended (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 19).

FY 07 Department Update: The new CERAP draft currently being field-tested provides that a safety plan must be developed whenever a caregiver has a prior abuse history.

FY 08 Department Update: The recommendations resulting from the pilot were submitted to the Safety workgroup, which has been meeting regularly to incorporate these recommendations. There is a possibility of some additional slight modifications to incorporate the recent Department focus on Trauma Informed Practices. Procedures 300, Appendix G: Safety Assessment Enhancement has been revised and will be implanted when SACWIS changes are completed. The anticipated implementation date is July 2009.

FY 08 OIG Response: The Department's response does not address the need to amend Teen Parent procedures.

Pregnant or parenting teen wards who continue to be involved in violent relationships should not be allowed to remain in an independent living apartment. The Teen Parent Service Network and DCFS need to develop and make available specialized crisis foster placements that can accept a teen parent and his or her children on an emergency basis while an emerging, potentially violent situation is de-escalated and the safety and well-being of the parent and child is protected. As part of a CERAP plan, the pregnant or parenting teen should attend domestic violence counseling and participate in aggression replacement treatment (involving social skill, anger management and moral reasoning programming), the parent and child/ren should remain in the specialized crisis placement or other least restrictive setting that has 24-hour supervision until the parent successfully completes the individualized violence reduction treatment program (from OIG FY 04 Annual Report, Death and Serious Injury Investigation 19).

FY 07 Department Response: These recommendations and redacted copies of this report were sent to the committee reviewing CERAP.

FY 08 Department Update: The Department has transitional living programs that manage pregnant and parenting teen cases. The Department moved into Performance Based Contracting in July 2008 and now all independent living and transitional living programs have standard program plans with separate payment rates. Transitional living programs were also established in FY 07 for developmentally delayed youth, a specialty population for which the Department has increased resources.

In cooperation with the National Alliance for the Mentally Ill (NAMI), supportive psycho-educational and peer support programming should be developed for teen parents with Major Depression, Bipolar Disorder, and other psychotic disorders. Staff from NAMI have offered to work with the teen parent initiative to set up and pilot a short-term psycho-educational mental health and peer support group for appropriate teen parents with mental health problems (from OIG FY 05 Annual Report, General Investigation 26).

FY 07 Department Update: The Department will work with the National Alliance for the Mentally Ill (NAMI), regarding supportive psycho-educational and peer support programming for teen parents with Major Depression, Bipolar Disorder, and other psychotic disorders.

FY 08 Department Update: DCFS, NAMI, TPSN and a private agency have been working closely to implement this program. A work group was formed and determined that NAMI had a curriculum that would meet the mental health needs for teen parents in care and recommended that a private agency would work with several teen moms with a mental health diagnosis to implement the program. A facilitator from NAMI and a teen parent will facilitate support groups with teen parents in residential care that have had a mental health diagnosis. The support groups will be on-site where the teens are located.

APPENDIX

APPENDIX A:
Sierra Lexington Investigation

OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

REDACTED REPORT

This report is being released by the Office of the Inspector General for 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: *08-0350*

Child: Sierra Lexington (DOB: 8/05, DOD: 8/07)

In August 2007, the Office of the Inspector General received notification of the death of almost two-year-old Sierra Lexington. Sierra was transferred from South Hospital and was admitted to West Hospital in August 2007. Medical staff suspected child abuse and determined that Sierra's condition was caused by either shaken baby syndrome or suffocation. After she was pronounced brain dead, Sierra was taken off of the ventilator and pronounced dead.

The police report indicates that Joan Kaplin was babysitting Sierra. Sierra allegedly ran and hit her head on the coffee table. Ms. Kaplin claimed that Sierra laid down for a nap and when she later checked on the child, blood was coming from her mouth. Interviews with Ms. Kaplin's 11-year-old twin daughters revealed that Ms. Kaplin shook Sierra and later threw her to the floor. Joan Kaplin was indicated for Death by Abuse (Allegation #1) and Head Injuries by Abuse to Sierra (Allegation #2), and Substantial Risk of Physical Injury to her daughters Yvette and Yvonne (Allegation #60). She is also charged with first-degree murder and currently awaits trial.

Prior to Sierra's death, Joan Kaplin was the subject of two separate DCP investigations after Sierra and 12-month-old Tatiana Camden were injured in Ms. Kaplin's care. The Office of the Inspector General initiated an investigation pursuant to its directive to investigate all child deaths in which there was an open DCFS case or prior DCFS involvement within the past twelve months.

INVESTIGATION

DCP Investigation SCR# 99-A

On February 22, 2007, a West Hospital social worker contacted the State Central Register (SCR) to report suspicious bruising on the left side of 18-month-old Sierra Lexington's face. Philip Lexington, Sierra's father and custodial parent, informed the social worker that Sierra's mother, Tara Gould, picked up their daughter from him on Tuesday, February 13, 2007. Sierra remained in Ms. Gould's care until Thursday, February 22 because Mr. Lexington was ill. He told the social worker that he noticed bruising to Sierra's face when he picked his daughter up from the mother's residence. As Ms. Gould was not home, Mr. Lexington asked the mother's roommate, Joan Kaplin, how Sierra sustained the injuries. Ms. Kaplin allegedly responded that the child's pacifier caused the bruises. Mr. Lexington later took Sierra to the hospital for examination.

The investigative file contained a Patient Record note written by the social worker in which Mr. Lexington provided the social worker with the name and address of Sierra's primary care physician, her diagnosis of asthma, and Albuterol prescription. Mr. Lexington reported that he and Ms. Gould shared custody of Sierra. He also shared that Ms. Gould worked part-time and that he felt that he cared for their daughter 95% of the time.

Also in the Patient Record note, Ms. Gould told the social worker that on Tuesday she left Sierra in Joan Kaplin's care and went to her mother's home because her step-father had been found dead in bed. Ms. Gould reported that she stayed at the maternal grandmother's home from February 13 to February 22. On February 22, she returned to Ms. Kaplin's home for 45 minutes, checked on Sierra who was asleep, then left. Ms. Gould said that the week prior to Sierra's hospital admission Ms. Kaplin told her that Sierra had slept on her pacifier and as a result sustained scratch marks on her cheek. The social worker noted that the child had significant bruising to the cheek and neck.

Child Protection Investigator Keith Watkins was assigned to meet the 24-hour mandate. On February 22, Mr. Watkins interviewed Dr. Corey Tyson, the attending physician at West Hospital. Dr. Tyson stated that Sierra had bruising by her left eye and temple. The physician stated that the caretaker's account of how Sierra sustained the injuries was inconsistent with the injury. Dr. Tyson opined that the injury appeared as though someone had slapped the child. Radiology conducted a skeletal x-ray survey of the child, which initially produced negative findings.

CPI Watkins observed Sierra at the hospital and noted bruising near her left eye and on the left side of her face. His supervisor, Dawn Acosta, recorded in the investigation that Mr. Watkins contacted her and related that he observed, "bruises to the left side of the skull, under the left eye, and her left jaw is swollen."

During an interview with Dr. Ava Jepson of West Hospital's Child Protective Services Team, the OIG obtained photographs taken by a hospital social worker, which documented Sierra's injuries. Copies of the photographs were not contained in the DCP investigative file. Dr. Jepson stated that Sierra's injury was a slap mark and was caused by abuse.

In an interview with Investigator Watkins, Mr. Lexington said that when he picked Sierra up from her mother's home, he noticed bruises on his daughter's face. He reiterated that Joan Kaplin told him that Sierra had lain on a pacifier that caused the bruises. He stated that he immediately took his daughter to the hospital. Mr. Lexington also told the investigator that Sierra had resided with him and his family since birth and that he was Sierra's primary caregiver.

Mr. Watkins interviewed Sierra's mother, Tara Gould, who told him that a family emergency arose in which her stepfather died at her mother's home. She left her daughter in the care of Joan Kaplin. Ms. Gould said that Ms. Kaplin contacted her and said that Sierra had slept on her pacifier and sustained bruising on her face. Ms. Gould told the investigator that she was out of the home on Wednesday, February 21 assisting her mother with funeral arrangements and arrived home late. She said that she briefly checked on Sierra that evening and did not observe the marks that Ms. Kaplin claimed were on the toddler's face.

CPI Watkins informed the mother that she and Mr. Lexington needed to establish a safety plan for their daughter. Ms. Gould agreed to allow Sierra to remain in her father's care.[11] Dr. Tyson discharged Sierra to the care of her father, Mr. Lexington.[12]

[11] Contact notes, February 22, 2007, interviewees Tara Gould and Sierra Lexington.

On February 23, 2007, DCP opened a formal investigation, which was assigned to Child Protection Specialist Melody Poole and her supervisor, Sara Daye. At the time, Marcie Brown was temporarily assigned as the supervisor. Per the supervisory note, Ms. Brown advised Ms. Poole to "see the child in the home of the natural father Mr. Philip Lexington […] Assess the minor for any cuts, welts, or bruises[,] complete CERAP. Speak with the father to see if there are any custody issues. Assess the natural father[,] complete substance abuse and domestic violence screen. Complete home and safety checklist. Interview the natural mother[,] assess all adults in the natural mother's home[,] soundex all adults[,] complete substance abuse and domestic violence screens. Please follow rules and regulations for procedure #300 pertaining to allegation #11 Cuts, Welts, and Bruises."[13]

CPS Poole observed Sierra at the hospital on February 23 and noted "a slightly red mark on upper left chest; what appeared to be fresh bruises and a loop mark on left side of her face and red scratch mark under her ear. Father reported there was some [s]welling additionally near her ear area which CPS could not tell."[14] The investigator also remarked that Sierra seemed fretful and cried as if she was in pain when her father or the physician touched her. In a separate contact note, the CPS wrote that she observed a pacifier with square corners around the child's neck. After measuring the mark on the child's face with the pacifier, she noted that the pacifier did not match the mark.

On February 23, when interviewed by CPS Poole at the hospital, Mr. Lexington related that Sierra's mother, Ms. Gould, was not home when he picked up their daughter. Prior to picking up Sierra, the father called Ms. Kaplin and asked her to prepare the child. When Mr. Lexington arrived at the home, Ms. Kaplin told him Sierra was sick and had diarrhea. He noticed bruises on the child's face and Ms. Kaplin said that a pacifier caused them. Mr. Lexington stated that he took Sierra home and gave her a bath. In his opinion, Sierra acted strangely from the time she arrived at his home, lay around all day, and seemed less energetic than usual. When he later placed her in a chair, she began "hollering and crying like she was in pain." Mr. Lexington said that he consulted a nurse who lived nearby and was advised to take Sierra to the hospital because, in the nurse's opinion, a pacifier could not have caused the bruises. The father said that he transported Sierra to the hospital around 2:30 p.m. or 3:00 p.m.

Per the investigation notes, Mr. Lexington informed the investigator that he cared for Sierra "95% of the time" and would occasionally ask Ms. Gould to look after their daughter. He stated that he would have Sierra for as long as 14 days and Ms. Gould would not check on Sierra, whereupon he would contact the mother. The father denied any past or existing domestic violence between him and Ms. Gould, denied having any mental health issues, and denied that Ms. Gould had ever physically abused Sierra.

Mrs. Rosa Dunning and Mr. Herman Dunning, Sierra's paternal grandmother and paternal step-grandfather respectively, also said that Sierra was unusually less active when she returned to their home. Mrs. Rosa Dunning, who Ms. Poole listed as a collateral contact, told the investigator that at home she undressed Sierra and noticed two reddish scratches and discoloration near the child's eye and discoloration under her jaw. Initially, Mr. Dunning, the grandfather, only saw a small mark on her face near her eye. When he later observed Sierra in the light, he noticed that the entire left side of her face was

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[12] Sierra was readmitted to West Hospital on February 23 when, upon further review of the skeletal survey, doctors raised concerns of potential spinal injuries. Initial X-ray findings were consistent with non-accidental trauma compression injury to the spine, malignancy, or homocystinuria (a hereditary disorder of the metabolism of an amino acid). On February 26 an MRI was conducted and produced normal, unremarkable findings.

[13] Supervisory Note, February 23, 2007.

[14] The investigator also completed a body chart for Sierra on February 23 on which she recorded observing loop mark bruises above the child's left ear, a bruise behind the left ear, a red scratch near the jaw, and a slight red bruise on the child's chest. She also wrote "reported swelling" as to an area near Sierra's left ear.

swollen and appeared to start "[from] her hairline like it could have been a handprint." Sierra did not want to walk or eat. The investigator wrote that during her interview with Mrs. Dunning, she "explained legal custody issues per [Ms. Gould] and her right to take her baby [E]ncouraged her to be cooperative with the mother to ensure family continues to be involved with child with least disruption to child's emotional well being."

On February 23, CPS Poole made an unannounced visit to Ms. Gould's home and conducted an interview. In the interview, Ms. Gould told Ms. Poole that she lived with her friend, Joan Kaplin, and Ms. Kaplin's twin daughters. She said that Sierra spent time at both her residence and Mr. Lexington's home. Ms. Gould stated that on Monday, February 19,[15] she went to the home of her mother, Rayna Valdes, because her stepfather had just died in the home. Ms. Gould said that she left Sierra with Ms. Kaplin who always babysat Sierra when she went to work. When Ms. Gould returned home on the following Wednesday for a change of clothes, she "peeked in the room" and found Sierra asleep. The mother told the investigator that Ms. Kaplin had informed her that Sierra had slept on her pacifier, which left "two little scratches on the left side of her face near her eye." The mother stated that she did not use corporal punishment on Sierra and that Ms. Kaplin's twins were not aggressive with her daughter. She also said that she had known Ms. Kaplin for a number of years and that Ms. Kaplin "does not discipline her children or any children."

CPS Poole asked Ms. Gould to accompany her to visit Sierra in the hospital so that Ms. Gould would not be perceived as unconcerned about the child. Per the investigator's notes, the mother responded that she "has just been overwhelmed and in shock about everything including my stepfather's death and felt the baby was okay at the hospital since the father was there and nobody said there was anything more serious. Now I will make sure to go."

In an interview with the OIG, Ms. Poole stated that Ms. Gould was under the impression that an order of protection had been filed against her barring any contact with Sierra. The CPS said that Mr. Lexington thought that the safety plan implemented by CPI Watkins was an order of protection. Ms. Poole therefore created a new CERAP on February 23 and modified the safety plan to allow Ms. Gould contact with the child.

In the Safety Assessment factors, the investigator marked that there was reasonable cause to suspect that a member of the household caused moderate to severe harm or had made a plausible threat of moderate to severe harm to the child. The CERAP reads:

> Twelve-month-old Sierra Lexington was reported to have been picked up by natural father, Mr. Philip Lexington from mother[']s] (Ms. Tara Gould) residence after visiting a week, and observed minor with bruises on the left side of her face. Child was reported left in the care of Ms. Joan Kaplin, babysitter.

Both parents agreed to the safety plan which indicated that Sierra would remain in the father's care and stipulated that Joan Kaplin would have no unsupervised contact with the child pending the outcome of the investigation. In the CERAP, CPS Poole wrote "In order to terminate the plan, child will be determined safe. Weekly redeterminations are the time frames imposed by this plan until plan is terminated. This plan is from 2/23/07 – 3/2/07." The safety plan, however, was never approved. Supervisor Sara Daye's signature appears under the safety assessment and safety decision sections of the CERAP with a date of February 24 (Saturday). However, the safety plan dated February 23 was not signed by Ms. Daye, but by

[15] Dates recorded in CPS Poole's interview with Ms. Gould differ from those noted in the social worker's patient record upon interviewing the mother.

CPAS Marcie Brown under "Supervisor gave verbal approval by phone" dated March 1, 2007 – that is, 5 days following the 24 hours time frame required by Procedures 300.[16]

Per the contact note, Ms. Gould provided CPS Poole with her mother, Rayna Valdes, as a collateral contact. As the investigation did not contain documentation of an interview with Ms. Valdes, OIG investigators asked Ms. Poole if she spoke with the maternal grandmother to verify Ms. Gould's whereabouts during the incident. The CPS stated that she spoke with Ms. Valdes in-person who confirmed that Ms. Gould was assisting her with funeral preparations at the time of the incident. The CPS said that she failed to document the interview in a contact note.

On February 23, CPS Poole also interviewed Joan Kaplin, the alleged perpetrator, who stated that she had two adult children and two twin daughters, Yvette and Yvonne Kaplin (age 10). Ms. Kaplin said that she often cared for Sierra when her mother, Ms. Gould, went to work. Ms. Kaplin also informed the CPS that she, Yvonne, Yvette, and Sierra would sleep together in one bed. Ms. Kaplin stated that she noticed "two little scratches where her pacifier clamps her clothes; the scratches came from it; I saw no red bruises on her face." She said that she told Ms. Gould about the injuries and "even showed" Mr. Lexington. "If [Sierra's] face had been that bruised," Ms. Kaplin told the investigator, "[Mr. Lexington] would have said something."

In the interview, Ms. Kaplin said that the only thing she could think of was that Sierra fell twice: once in the living room when running and playing and once in the dining room. CPS Poole never asked Ms. Kaplin for additional details as to specifically when and where Sierra had fallen and what the child was doing at the time of those falls. Ms. Kaplin told the investigator that she gave Sierra baby Tylenol as the child had a fever and swollen gums the night before she returned to her father. Sierra did not appear to be in pain when she left with Mr. Lexington at about 11:00 a.m. on February 22. Ms. Kaplin added that she had nothing to hide and would take a lie detector test if necessary.

Beside her ten-year-old daughters, Ms. Kaplin named four other children, also residents of the same building[17], as present during Sierra's reported falls. The investigator did not document obtaining additional information regarding the children such as their last names or ages. In the OIG interview, Ms. Poole was asked if she interviewed the children named by Ms. Kaplin as required by Procedure 300.[18] The CPS answered that she attempted to contact the children's parents but was unable to find them. These attempts were not documented in the investigation. Ms. Poole's former supervisor, Ms. Daye, did not waive these contacts.

During her OIG interview, OIG investigators showed Ms. Daye the SACWIS screen of her approval of the investigation. Ms. Daye informed the OIG investigators that prior to approving the investigation she did not discuss with Ms. Poole how to obtain interviews with the children.

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[16] Procedures 300 Appendix G, which addresses the purpose of and how to complete the CERAP, states that the worker develops a safety plan if the safety decision is checked "unsafe" and the supervisor or designee must sign the form within 24 hours after the worker has signed it. If the worker has signed the CFS 1441-A [Safety Plan] on a weekend or holiday and more than 24 hours will elapse before the supervisor can sign the form, the worker shall obtain the verbal approval of the supervisor or designee by phone. The supervisor shall then sign the Safety Plan on the next working day. If the supervisor will not be available to sign the form on the next working day, but has access to a FAX machine, the Safety Plan shall be faxed for the supervisor's signature. In all other instances when the supervisor who gave verbal approval will not be available to sign the Safety Plan due to a prolonged absence, another supervisor may sign the plan.

[17] The building consists of three to six residence units.

[18] Appendix B – Procedures 300 Allegation: Cuts, Bruises, Welts, Abrasions and Oral Injuries section c, (4) Requirements for Formal Investigation (G) Interview all identified witnesses who are reported to have knowledge of the incident that resulted in cuts, bruises, or welts.

In the Checklist of required contacts, CPS Poole listed Wanda Stack, the building landlord, as a collateral contact and as an "Identified Witness (knowledge of incident)" though during the course of the investigation no one had reported that Ms. Stack witnessed Sierra's alleged falls. On February 23, Ms. Stack told the investigator that she noticed no marks on Sierra when she saw the child the day before the incident (at 9:00 p.m.) as well as on the morning that Sierra returned to her father's care (at 8:40 a.m.). To the landlord's knowledge, no one used corporal punishment with the children so she could not understand how Sierra could have bruises. In Ms. Stack's opinion, everyone was usually careful with Sierra and many of the children from the building visited Ms. Kaplin because she was "mild mannered." Investigation notes do not indicate that the investigator asked the landlord for additional information about the children who were reportedly present at the home when Sierra sustained her injuries.

Ms. Poole interviewed Ms. Kaplin's ten-year-old twin daughters, Yvette and Yvonne, on February 23. Both children stated that Sierra sometimes lay on her pacifier when sleeping and that they noticed two "little scratches" on her face. Yvette added that other children in the building who visited were never aggressive with Sierra and Ms. Gould never hit or slapped her daughters. Yvette told the investigator that she saw Sierra fall twice: first, in the living room onto her face and second, onto the dining room floor a day before Mr. Lexington picked up Sierra.[19] The girls confirmed that they and Sierra slept with their mother. Yvette and Yvonne also denied that Ms. Kaplin used corporal punishment with them or with Sierra.

According to the investigation, CPS Poole observed the basement apartment and the rooms in which Sierra allegedly fell. In the OIG interview, the CPS stated that in her observation of the areas where Sierra reportedly fell she did not view or identify any objects or furnishings that could have caused injuries to the child's face. The living room was carpeted and the kitchen floor was tile.

In the DCP investigation, Ms. Poole noted that Ms. Gould and Ms. Kaplin informed her that the smoke detector needed new batteries, which would be purchased on the following day.

In a case supplementary police report, Detective Jeremy Graham wrote that on February 24 he made contact with Investigator Poole who related that she was unfounding the case for abuse. The call detail report for Ms. Poole's wireless phone contains a February 24, 8:57 PM outgoing call to the Police Department which lasted 10 minutes. The investigation does not document the contact. The call detail shows that the investigator phoned Joan Kaplin's residence, directly before calling the police. Also, the calls immediately after the call to police are to West Hospital's Emergency Room and to Philip Lexington.

The investigation contains a Safety Plan Termination Agreement signed by Tara Gould on March 1, 2007. However, the form drafted for the father's approval was signed only by supervisor Sara Daye, but not by Mr. Lexington. Ms. Daye told OIG investigators that she was unsure why the safety plan was terminated.

Upon notification that the safety plan would end, Mr. Lexington became upset and told CPS Poole that Ms. Gould arrived to pick up Sierra. According to investigation notes, the father stated that his mother had taken Sierra elsewhere and that he would not allow Sierra to return to Ms. Gould because the child had a medical appointment the next day. After-care instructions provided by West Hospital Pediatric

[19] During her interview with Yvette, CPS Poole observed the minor wearing a cast and ace bandage on her right hand. Yvette told the investigator that she fell onto her arm when she and her sister were playing. They collided when running and looking in different directions. Ms. Poole re-interviewed Yvonne and Ms. Kaplin who confirmed the account of Yvette's injuries. The investigator also interviewed the doctor who treated Yvette's injuries. The doctor told the investigator that the injury was not consistent with physical abuse and could have been caused by the impact of Yvonne falling onto Yvette.

Emergency Department directed Mr. Lexington to complete a follow-up visit with Sierra's primary care physician, Dr. Kovach, in 1-2 days. However, Investigator Poole incorrectly explained that Ms. Gould had a right to pick up her daughter and only the mother could consent for Sierra to receive medical attention. The investigator also asked Mr. Lexington to ensure that Sierra was released to Ms. Gould upon her return. The CPS also told Mr. Lexington that Ms. Gould could charge him and his relatives with kidnapping.

On March 5, DCP manager, Rhonda Baer, reviewed the investigation for safety plan reassessment and compliance. She noted that the updated safety plan completed on February 23 was terminated on March 1 but was never submitted for approval. In the supervisory note, Ms. Baer wrote that a new CERAP would have to be completed to reflect the safety of the child. Ms. Baer also wrote that the supervisor or the Advanced Specialist would be responsible for completing the task by the close of the day because Ms. Poole would be away from the office until March 7.[20] CPAS Marcie Brown updated the CERAP on March 5 and marked it safe to reflect Sierra's placement with her father. Ms. Baer approved the updated safety assessment.

On March 7, Investigator Poole accompanied Ms. Gould to the home of Mr. Lexington and Mr. and Mrs. Dunning, Sierra's paternal grandparents, to pick up Sierra. According to the contact note, no one answered the door for several minutes until the investigator and mother enlisted the aid of a neighbor. Mr. Dunning answered the door and called his wife who stated that she attempted to call the investigator because she planned to return Sierra to Ms. Gould. Mr. Dunning told the investigator that it seemed as if the "CPS is against his son [Philip Lexington] and on the mother's side." The investigator wrote that she responded that "there are no sides; all is in the best interest of the child and that the mother has a right to pick up her child as the legal custodian. Natural father was reported not[.] CPS thanked paternal grandmother for cooperation and mother informed her that she will return child on tomorrow (3/8/07)." Ms. Poole also wrote, "*Alleged victim was reported not to have had a follow up visit because CPS informed relatives that the father cannot consent to medicals. Mother was requested to complete follow up visit on 3/8/07 with Dr. Kovach (primary physician).*"[21]

Per the investigation notes, Ms. Poole interviewed Dr. Kovach, Sierra's primary care physician, on April 18, two days prior to the closing of the investigation. The CPS wrote:

> […] Doctor reported last visit for Sierra was 3/8/07; Shots are up to date; She was in good general physical health; There have been no safety concerns; nor signs of abuse or neglect.

OIG investigators asked Ms. Poole how she determined that Ms. Gould was the child's legal custodian. The CPS related that her determination was based on self-report of the mother and the accounts of other family members. She also stated that she viewed Sierra Lexington's birth certificate and saw Tara Gould's name as the mother, however, the CPS did not recall if she saw Philip Lexington's name as the child's father.[22] The CPS said that her understanding of fathers' custodial rights was not based on training received through the Department, but rather on her experiences with juvenile court in which mothers often disputed paternal custody rights. Ms. Poole said that she assumed that Ms. Gould had full legal custody of Sierra and could solely consent to medical attention as Mr. Lexington had not pursued custodial rights thorough child support or through Domestic Relations. Case notes written by the CPS

[20] A review of March 2007 Daily Staff Attendance Report for Melody Poole showed that March 6 to March 7 were the investigator's regular days off.
[21] Contact notes, March 7, 2007, interviewee Rosa Dunning (Emphasis by OIG).
[22] Sierra's birth certificate indicates Tara Gould as the child's mother, but does not list a father.

show Ms. Gould attesting to joint care and custody of Sierra, as well as Mr. Lexington's assertion that he was primary caregiver "95% of the time."[23]

In the OIG interview, the supervisor, Sara Daye, recalled that Ms. Gould and Mr. Lexington had arranged for the father to care for Sierra because the mother wished to continue working. She also stated that Ms. Poole reported that Mr. Lexington was an involved father and that Sierra appeared well-cared for and comfortable with him. Ms. Daye could not remember how the investigator determined Ms. Gould to be the custodial parent, but said that perhaps the investigator presumed Ms. Gould the legal custodian because the parents were not married.

According to supervisory notes written by secretary Kelli Zimmerman, Subsequent Oral Report (SOR) conferences were held on March 1 and March 8 with "Gladys Rendon, DCP Regional Administrator, Rhonda Baer, Child Protection Manager, Sara Daye, Public Service Administrator and Melody Poole, Child Protection Investigator" in attendance. With regard to the March 1 meeting, Ms. Zimmerman wrote "Recommendations were as follows: 1) CPI continues to investigate this case. CPI is waiting for report from doctor before the final finding." Regarding the March 8 meeting, notes read, "Recommendations were as follows: 1) CPI was instructed to contact legal regarding who will pay for copies of criminal arrest records." In the OIG interview, Ms. Poole said that she could not remember what was discussed during the SOR meetings, but she did recall that discussion revolved around Mr. Lexington's background and obtaining his criminal record from the police.

LEADS check requested by CPS Poole for Mr. Lexington showed:

3/01/06 Ordinance and unspecified statute – no disposition

2/15/05 Aggravated criminal sexual assault Victim–Nine – no disposition.

12/4/04 Possession of cannabis changed to conspiracy, possession of cannabis and stricken on leave

5/21/01 Possession of controlled substance – sentenced to one year probation

3/29/01 Possession of controlled substance – two counts – not prosecuted

On March 1, the investigator discussed the criminal record with Mr. Lexington. Regarding the sexual assault charge, Mr. Lexington told the investigator that he never went to court and was never charged. He also said that the alleged victim denied the allegations when interviewed by a detective.[24]

On March 8, CPS Poole spoke with Detective Jeremy Graham who had to interview Ms. Kaplin before concluding the case. The investigator wrote that the detective stated:

> […] father and grandmother appears to want custody of the child; that child was probably lethargic because the caretaker had given her Tylenol[25] and after she went to the father's

[23] Contact notes, February 23, 2007, interviewee Philip Lexington.
[24] The OIG unsuccessfully attempted to retrieve the underlying documents pertinent to the charge of aggravated sexual assault. The lack of records suggests that Philip Lexington was arrested but was not formally charged and not convicted.
[25] Acetaminophen is the active ingredient in children's Tylenol, and side effects of acetaminophen do not include lethargy or drowsiness.

> house; they gave her Tylenol[.] which bruise appeared to be a hand print, but he is unsure; stated case will probably be a clear disposition and closed […]

When CPS Poole observed Sierra at the maternal grandmother's home on March 8, Ms. Gould told the CPS that she would obtain a toddler bed or crib for the child before returning to their residence with Ms. Kaplin.[26]

On March 10, the investigator phoned Dr. Corey Tyson, Sierra's attending physician, who could not make a clear determination whether the bruises were the result of physical abuse. The physician said that the injuries might have been accidental or caused by falling, but not by a pacifier. Dr. Tyson suspected abuse, as there was no explanation of how Sierra sustained the injuries.

The investigator made an unannounced visit to Ms. Gould's home on April 13 and observed Sierra sleeping in a toddler bed with a pacifier in her mouth. The child had no signs of abuse or neglect.

The report was closed and unfounded on April 20, 2007. The rationale stated:

> Although Sierra was observed with bruises on her face by CPS, natural father, attending doctor and social worker; there is no credible evidence to support how minor received the injuries based upon statements by Dr. Corey Tyson, and household members to include natural mother, Ms. Tara Gould, babysitter, Ms. Kaplin, her daughters and landlord who reportedly observed no bruises. Therefore, the allegation is unfounded.

In her OIG interview, CPS Poole was asked if she had any concerns about returning Sierra to Ms. Gould's home. The investigator stated that her only concern was that Ms. Gould did not have a toddler bed for Sierra, which the mother had obtained before the investigation closed. The CPS added that three individuals – the father and two paternal grandparents – had contact with Sierra before she was transported to the hospital and therefore the CPS could not be certain if something had occurred in the time between leaving Ms. Gould's home and her evaluation at the hospital. Ms. Poole stated that maybe "something happened" in that time frame. The investigator also stated that she had no supervisor to approve an indicated finding based on the evidence she had gathered.

During the OIG interviews of doctors from West Hospital, they were asked why they did not appeal the unfounded finding as mandated reporters. Both doctors stated that the notices they received from the Department make it difficult for them to appeal since the notices only contained the name of the alleged perpetrator and the SCR number, but not the alleged child victim's name. They receive hundreds of such notices each year. Rule 300.130 requires such notification to contain the name of the child who was the subject of the report. It appeared from the record that when notices were sent by child protection they conform with Rule 300, yet notices generated and sent by the SCR contained only the name of the alleged perpetrator and the SCR number.

DCP INVESTIGATION SCR# 100-A

On May 22, 2007, one month after the closing of SCR# 99-A, Liz Easter transported her 12-month-old daughter, Tatiana Camden (DOB 5/06), to Central Hospital emergency room due to concerns of facial bruising and a head injury. Tatiana was later air-lifted to West Hospital. The day prior to Tatiana's hospital admission, the child was left in the care of Joan Kaplin, who was reportedly her godmother. On May 23, 2007, a West Hospital social worker contacted the SCR hotline to report suspected abuse of Tatiana who presented with bruising and head trauma. The social worker indicated that the child's injuries were "extremely inconsistent with Joan's explanation" that the child might have fallen in the

[26] Case note created on March 8, 2007.

kitchen while unsupervised and that a fall from standing would not cause the injuries that Tatiana sustained.

In a Patient Record note contained in Tatiana's West Hospital medical record, the social worker documented her interviews with Tatiana's mother and Ms. Kaplin. The mother, Ms. Easter, stated that she left Tatiana with Ms. Kaplin and took her 12-year-old daughter Felicia and Ms. Kaplin's twins to attend a health seminar. A few hours after being out, the mother phoned Ms. Kaplin who told her that Tatiana had fallen. Ms. Easter was unsure how Tatiana could have fallen because she could not yet walk without assistance. Tatiana could pull to stand and had started cruising.

The social worker contacted Ms. Kaplin via telephone and learned from Ms. Kaplin that:

> She was in the front room talking on the phone and [the patient] and 1½ [year old] were in the kitchen on the floor. She heard a cry [and] went to find her on her side on the tile over concrete floor. She noticed a red mark developing and used a cold wash clothes [*sic*]. She denied any other adults were over in the house or that the other young child could have picked her up and dropped her. She describes the only thing on the floor she believes she could have pulled to stand on was a small refrigerator she has on the floor in the kitchen. She describes that when she did go in to the kitchen she saw the other child sitting on the ground and calm.

Child Protection Specialist Tennika Jones and her supervisor, Zebretta Williams, were assigned to the investigation.

On May 23, CPS Jones interviewed Ms. Easter at the hospital. Ms. Easter told the investigator that she visited Ms. Kaplin at about 3:15 p.m. on Monday, May 21, before taking her older child Felicia to a health seminar. Ms. Kaplin's twin daughters, Yvette and Yvonne, accompanied Ms. Easter to the seminar and Tatiana was left in Ms. Kaplin's care. About two hours later, Ms. Easter phoned Ms. Kaplin to check on Tatiana. Ms. Kaplin informed the mother that the child had fallen and had a lump on her head and that she had applied a cold compress. Per the investigation notes, Ms. Easter stated that she was not very concerned because she was en route to Ms. Kaplin's home. When she arrived at 6:30 p.m., she observed some swelling on Tatiana's left temple. Ms. Easter gave the child baby Tylenol and continued applying a towel with ice. The mother took Tatiana home, and though the swelling had decreased, she continued applying the cold compress. Ms. Easter said that the following day, May 22, Tatiana appeared fine. At about noon, however, she noticed that the swelling had worsened and caused Tatiana's ear to appear "slumped over." Tatiana also vomited. Ms. Easter gave Tatiana Motrin and took her to Central Hospital where she was informed that her daughter had sustained a skull fracture. The child was air lifted to West Hospital where a CT scan confirmed a depressed skull fracture and underlying subdural hematoma.

Ms. Easter informed Investigator Jones that Ms. Kaplin never provided her with a clear explanation as to how Tatiana fell. Ms. Kaplin told the mother that she was on the telephone at the time and did not witness the incident. As Tatiana and 21-month-old Sierra Lexington were reportedly playing together in the kitchen, Ms. Easter surmised that Sierra could have possibly attempted "to handle (pick up or carry) Tatiana and either dropped her [or] knocked her down." Ms. Easter told the investigator that she was aware of the previous DCP investigation pertaining to alleged neglect or abuse of Sierra by Ms. Kaplin and that Ms. Kaplin informed her that the report was unfounded.

On May 23 at the hospital, CPS Jones observed 12-month-old Tatiana who had bruising to her left eye. Ms. Easter told the investigator the bruises were not initially visible on the day of the fall, but appeared several hours later. The investigator did not observe a lump or bruising on the left side of Tatiana's head as previously reported.

Tatiana was referred to the West Hospital's Child Protective Services Team for an evaluation of her head injury. On May 23, CPS Jones phoned Dr. Ava Jepson, Child Protective Services physician, who reported that the child sustained a "small impact" skull fracture with multiple cracks and fractures. The major concern was that the incident was un-witnessed. From the conversation with Dr. Jepson, the investigator wrote, "initial assumption is Tatiana was 'dropped from height'."

In the CPS Consensus Report and MPEEC Expert Opinion, Dr. Jepson wrote that Ms. Easter had been interviewed by a hospital social worker and was aware of Ms. Kaplin's prior DCFS involvement. Ms. Easter stated that Ms. Kaplin told her that a "'baby daddy' had called in a 'bogus report' about 'someone slapping the 1 ½ year old [Sierra]'." Dr. Jepson also wrote:

> Tatiana is a one year old who is transferred to our hospital from Central Hospital for evaluation and treatment of a skull fracture and questionable underlying small subdural. According to her mother, Liz Easter, Tatiana had been in the care of her godmother and neighbor, Joan Kaplin, when she had an unwitnessed fall or injury. Tatiana had a goose egg and then was not acting herself and vomited, leading Liz to seek medical attention on Tuesday, May 22. […]
>
> Given [prior DCFS] history, and knowing that Tatiana cannot do much more than crawl or stand on her own, we are very concerned that the mechanism of an unwitnessed fall may not fully explain the extent of Tatiana's injury. Her skull fracture is complex and required enough force to fracture and depress the skull, as well as cause a small bleed underneath. The extent of the injury and lack of unwitnessed mechanism, as well as the previous DCFS history in the caregiver's home, led us to file with DCFS for an investigation.[27]

In the report, Dr. Jepson noted that CPS would continue working with DCP and the police during the course of the investigation.

CPS Jones and her supervisor Zebretta Williams informed OIG investigators that they read through the prior investigation involving Sierra Lexington during the course of the new investigation. Ms. Williams said that she did not consider adding allegations as to Sierra because the report came in for Tatiana Camden not for Sierra. OIG investigators asked Ms. Williams if information from the prior investigation had any influence on how she supervised the May 2007 investigation. Ms. Williams noted that the prior was unfounded and, therefore, neither she nor her investigator could use any of the gathered evidence for the new investigation. The supervisor said that she did, however, find it suspicious that another young child was harmed in the care of the same alleged perpetrator.

On May 24, Ms. Jones interviewed Joan Kaplin at her home. Ms. Kaplin related that Ms. Easter arrived at her home on May 21 and asked if Yvette and Yvonne could join Felicia at the seminar. Ms. Kaplin agreed and asked Ms. Easter if she wanted to leave Tatiana in her care rather than take the 12-month-old to the meeting. Per Ms. Kaplin, Ms. Easter agreed and left without saying goodbye to Tatiana. Tatiana cried after Ms. Easter and the older children left. Ms. Kaplin stated that after crying, the toddler fell asleep in the living room for less than half an hour. Ms. Kaplin said that she observed Tatiana scoot off of the couch and crawl into the kitchen. Sierra, who was also present, reportedly followed Tatiana into the kitchen where they played on the floor. Ms. Kaplin stated that she was positioned on the end of a couch and could see the children by standing and glancing around the wall into the kitchen. Ms. Kaplin said that she received a telephone call from her sister and remained on the phone for at least 30 minutes. While speaking with her sister, she continued to check on the children who were in front of a mini-fridge.

[27] CPS Consensus Report and MPEEC Expert Opinion, Date of Report, May 25, 2007, Patient, Tatiana Camden.

Reportedly, she heard a loud thump minutes later and Tatiana began to scream. According to Ms. Kaplin, she immediately went into the kitchen to find Tatiana lying on the floor on her left side. She said that when she picked up the child, she noticed a small lump on the left side of her head just above the ear.[28] Ms. Kaplin then applied a cold towel. Shortly after, Ms. Easter called to check on Tatiana and Ms. Kaplin informed her of the incident.

Ms. Kaplin denied causing intentional harm to Tatiana. CPS Jones wrote "Joan states in hindsight, she recalls hearing her 1 year old goddaughter Sierra keep repeating 'walk,' just before the thump, and now believes Sierra was trying to stand Tatiana up and make her walk and may have either pulled or pushed her down, causing her to hit [her] head on hard floor. Joan states that is what she believes, but she did not see Tatiana fall."

Ms. Kaplin provided Investigator Jones with her sister's telephone number. Ms. Jones told OIG investigators that she did not attempt to contact the sister to verify that she had phoned and spoken to Joan Kaplin at the time of the incident.

On May 24, CPS Jones also interviewed Tara Gould who resided with her 12-month-old daughter Sierra, Ms. Kaplin, Yvette and Yvonne Kaplin, and Ms. Gould's paramour DeSean Johnson. Ms. Gould told the investigator that Ms. Kaplin was her godmother and had cared for her during her childhood. The CPS also learned that Ms. Kaplin provided childcare for Sierra when Ms. Gould went to work. According to the contact note, Ms. Gould "never had any concerns regarding Joan's ability to care for Tatiana" and did not "believe that Joan would do anything to purposely hurt a child." Ms. Gould agreed not to leave Sierra unsupervised with Ms. Kaplin pending the DCFS and police investigations and said that her mother, neighbor, or sister would babysit Sierra. In the OIG interview, CPS Jones said that she did not ask Ms. Gould about Sierra's father or about any paternal involvement.

The CPS interviewed DeSean Johnson who said that he had known Ms. Kaplin for a year. He reported having observed Ms. Kaplin interact with Sierra and did not have any concerns regarding her ability to care for the child. Mr. Johnson told the investigator that both he and Ms. Kaplin were previously investigated after Sierra presented with bruises on her face. He stated that he did not witness Sierra fall, but Yvette and Yvonne were present and witnessed the incident. He denied ever causing injury to a child, having a criminal history, or ever being arrested or charged with a crime against a child.

CPS Jones interviewed Yvette and Yvonne Kaplin who reported that they were not home during the incident. Both children also stated that they received spankings or were placed on punishment when they were disobedient. Investigator Jones did not observe marks or bruises suggestive of abuse or neglect on either child. The investigator also observed Sierra Lexington who was nonverbal due to her age but was otherwise well and active with no signs of abuse or neglect. In the OIG interview, Ms. Jones stated that Sierra could not form sentences but might have been able to say single words.

The investigator observed the basement apartment and identified no visible hazards or structural concerns in the home. She also observed the kitchen area where the incident allegedly took place. The kitchen floor was made of tile over a concrete floor with no insulation or padding. On the Home Safety Checklist signed by Ms. Jones and Ms. Kaplin, the investigator only noted the family's need to replace smoke detector batteries.

[28] According to a case supplementary police report, Detective Jeremy Graham wrote that on June 1 he made contact with Joan Kaplin at her home. Ms. Kaplin related that Tatiana was playing on the kitchen floor while Ms. Kaplin was sitting at the table and that she left the kitchen to answer the telephone. While in the adjacent room, she heard Tatiana scream. When the babysitter entered the kitchen, she discovered the child lying on the floor on her left side and crying.

On June 12, CPS Jones contacted Detective Graham to determine the status of the criminal investigation. She was informed that law enforcement assessment would take place later that day. Per the investigation notes, the CPS phoned Ms. Kaplin on June 13 regarding the results of the testing. Ms. Kaplin reported that she was interrogated by the police for hours and underwent a polygraph test and failed. She also denied being charged.

According to supervisory notes written by PSA Zebretta Williams, services were offered to Ms. Kaplin but were refused. Tatiana's mother, Liz Easter, agreed to find alternate child care for her daughter and Ms. Kaplin agreed that "she will not care for any other children in her home."

Though Ms. Kaplin reported that Sierra was also left unsupervised in the kitchen, both the investigator and her supervisor told OIG investigators that there was no risk of harm to Sierra because she had not been injured in the May 23 incident and the prior report had been unfounded. Investigator Jones told OIG investigators that she did not recall discussing with her supervisor the possibility of indicating Ms. Kaplin for inadequate supervision or risk of harm to Sierra. Ms. Jones said that she expressed her concerns for Sierra's safety to Ms. Gould and talked with the maternal grandmother who said that she would assure that Ms. Kaplin no longer looked after Sierra. Ms. Williams, the supervisor, said risk of harm to Sierra was mitigated by the mother agreeing to find alternate childcare and Kaplin's agreement that she would not babysit anymore.

Although DCP unfounded allegations of Head Injuries by Abuse (#2) and Cuts, Welts, Bruises by Abuse (#11), Ms. Kaplin was indicated for Head Injuries by Neglect (Allegation #52) and Inadequate Supervision (#74). In the OIG interview, Investigator Jones said that abuse allegations were unfounded due to insufficient evidence to suggest that Tatiana's injuries were inflicted, and that neglect allegations were indicated because Ms. Kaplin was the only adult present and stated that she was not supervising the children when the incident which led to injuries occurred.

The formal DCP investigation closed on July 12, 2007. There is no evidence to suggest that CPI Jones or PSA Williams consulted with the police on criminal findings prior to closing the DCP investigation. According to a supplementary police report, Detective Graham requested that the investigation be classified "Suspended," pending further investigative leads.

AUGUST 2007 DEATH INVESTIGATION SCR# 100-B AND SCR # 537-A

At 1:00 a.m. on August 5, 2007, police contacted the SCR to report suspected physical abuse of Sierra Lexington. At 11:00 p.m. the previous night, Ms. Kaplin called 911 indicating that Sierra was not breathing and that blood was coming from the child's mouth.[29] Ms. Kaplin claimed that earlier in the afternoon a three-year-old child pushed Sierra down and caused her to hit her head and that prior to calling 911 she laid Sierra down and noticed blood in her mouth. The medical examination, however, showed that Sierra was a victim of shaken baby syndrome and a CT scan revealed diffuse cerebral edema, or swelling of the brain. At the time of the initial report, Sierra was sustained on a ventilator at South Hospital and was described as brain dead. Sierra was later transferred to the West Hospital where she was pronounced brain dead at 11:30 a.m. and taken off the ventilator at 1:25 p.m.

Child Protection Specialist Myra Boyce conducted the initial investigation. On that morning, CPS Boyce spoke to Sierra's mother, Tara Gould, who told the investigator that she and Sierra had resided with Ms. Kaplin for six to seven months. The mother said that the day before, she left for work around 2:30 p.m. and said goodbye to her daughter and her nephew, Vincent Gibbs, who had been at the home for the past three days. Ms. Gould told the CPS that Vincent and Sierra were left in Ms. Kaplin's care. She related

[29] Initial Report Narrative for SCR# 537A, August 5, 2007, 1:05 am.

that around 9:00 or 10:00 p.m. she received word at work that she should call home. When she spoke with Ms. Kaplin, Ms. Gould was told that Sierra fell and hit her head on a coffee table while playing with Vincent and that Sierra continued to play until she became sleepy. Ms. Kaplin told the mother that she checked on Sierra after putting her to bed and discovered blood coming from her mouth. Ms. Gould said that she told Ms. Kaplin that she should call 911. Ms. Gould informed Investigator Boyce that DCFS investigated a previous incident in February 2007 when Sierra's father took the child to the hospital for facial bruising. The mother said that Ms. Kaplin told her that Sierra had fallen in the kitchen. The CPS asked Ms. Gould why Ms. Kaplin continued to babysit Sierra though the mother was aware of a prior investigation. Ms. Gould responded, "because the report was unfounded, and I didn't suspect she would hurt my daughter."

CPS Boyce also met Sierra's father, Philip Lexington, at the hospital. Ms. Lexington stated that he learned of the recent incident from the landlord of Ms. Kaplin's building. He also recounted the details of the February 2007 incident, insisting, "this is the same thing that happened before" and "I still feel [Joan Kaplin] did something because of what happened in February."

The day after, the formal DCP investigation was assigned to Child Protection Specialist Dee Fitzgerald and her temporarily assigned supervisor Mia Hooper. CPS Fitzgerald re-interviewed Ms. Gould on this day. The investigator asked the mother if she was aware of the May 2007 DCP investigation regarding Ms. Kaplin and that Ms. Kaplin was not to baby-sit. According to the contact note, Ms. Gould stated that she "heard of an investigation."

The Medical Examiner conducted an autopsy on Sierra the day following Sierra's death. The doctor informed CPS Fitzgerald that the autopsy revealed four separate impact injuries to the child's head, subdural hematomas, retinal hemorrhages in both eyes, and facial bruising. In addition, the lingual frenulum – the tissue that attaches the tongue to the floor of the mouth – was lacerated from a blow to the mouth. The cause of death was blunt head trauma due to assault, and the manner of death was homicide.

When interviewed by Investigator Fitzgerald the day after Sierra's death, Nikki Kaplin said that she received a telephone call from her mother stating that something had happened to Sierra and that she arrived at her mother's home at the same time as the ambulance. She told the investigator that she took her sisters, Yvette and Yvonne, home with her and that she was willing to keep the children under a safety plan. Joan Kaplin and her daughter Nikki agreed to a safety plan which stipulated that Yvette and Yvonne would reside with their adult sibling Nikki and have no unsupervised contact with Joan Kaplin pending the outcome of the DCP investigation.

CPS Fitzgerald interviewed Yvette and Yvonne Kaplin that same day. When asked if she knew what happened to Sierra, Yvonne said that Sierra's cousin Vincent (age 3) pushed the toddler down twice in the living room and both times Sierra hit her head on the bottom part of a table in the living room. Yvonne told the investigator that each time she helped Sierra to her feet and that she told Vincent not to push Sierra. She also informed Ms. Fitzgerald that she never told anyone that Sierra had hit her head. Yvette told the investigator that Sierra fell in the living room and did not hit any objects then got up and continued playing. During the interview, Yvette suddenly stated, "She got hit in the head." Ms. Fitzgerald asked Yvette if she witnessed Sierra being hit to which the child responded that she did not. Ms. Fitzgerald asked Yvette when she discovered that something was wrong with Sierra. Yvette said at 11:30 p.m. Sierra coughed up blood and that her nose bled. Yvette told Ms. Fitzgerald that she helped by getting a towel and ice and that her mother, Ms. Kaplin, put the cold towel on Sierra's face and body.

When re-interviewed the next day, Yvette told Ms. Fitzgerald that Sierra was injured when she fell from the bed and hit her head on a fan, but said that she did not see the accident. Yvette added that she hit Sierra in the stomach with a basketball while playing and that Sierra fell and hit the back of her head

while in the kitchen. However, Yvonne told the investigator that the incident occurred in the living room. The children also reported different times at which Sierra began to bleed. Both children said that they did not tell the truth in their first interviews because they were afraid. Yvette said that she feared her mother would be jailed.

At the police station, Investigator Fitzgerald interviewed Anisha Valdes, who is Ms. Gould's sister, and the mother of three-year-old Vincent Gibbs, who was also in Ms. Kaplin's care at the time of the incident. Ms. Valdes told the DCP investigator that she had known Ms. Kaplin for a year and that Ms. Kaplin served as Vincent's sitter until the mother could find a childcare provider in her community. Ms. Valdes related that on the day before the incident, she picked up Vincent around 4:00 p.m. In the past when she arrived to pick up her son, Yvette and Yvonne usually greeted her with hello and sometimes with hugs. On that day, however, she rang the doorbell and observed one of the twins peer from the window then walk away. After waiting a few minutes, Ms. Valdes then knocked on the window. When Ms. Kaplin finally answered the door, Ms. Valdes noticed that the babysitter and her daughters' shirts were wet as well as the kitchen floor. Ms. Valdes stated that Ms. Kaplin said that Yvonne spilled a five-gallon water container while refilling it. Ms. Valdes also told the DCP investigator that she noticed blood stains on Ms. Kaplin's shirt. Ms. Valdes said that Ms. Kaplin ran and changed her shirt when the twins told their mother "your guns [*sic*] are bleeding."

Investigator Fitzgerald also interviewed three-year-old Vincent regarding the incident. According to the investigation notes, the child demonstrated limited verbal skills, but told Ms. Fitzgerald that Sierra had been crying. He also stated that Ms. Kaplin had hit him with a stick and on the head with her hand.

Two days after Sierra's death, CPS Fitzgerald interviewed Joan Kaplin at the residence of her daughter, Nikki.[30] Nikki had departed for work, leaving Ms. Kaplin and her daughters at the home alone. Per the contact note, the investigator asked Ms. Kaplin to recount how Sierra sustained her injuries. Ms. Kaplin stated that she saw Vincent hit Sierra on her head while the two children were playing and Sierra fell unconscious. Ms. Kaplin told the investigator that Sierra was crying and bleeding from her nose and mouth. Ms. Kaplin also stated that Sierra tripped and hit her head while playing with a ball. She said that Yvonne picked up the child and placed her on the couch. When the paramedics arrived, Sierra was crying and still breathing. Ms. Kaplin told the investigator that she had been scared and upset from the previous DCP investigation and that she did not contact anyone until after she called her daughter, who instructed her to call an ambulance and Sierra's mother. When CPS Fitzgerald questioned Ms. Kaplin about her presence at her older daughter's home, Ms. Kaplin responded that she had just been released from jail and that she could not return to the basement apartment under the current circumstances. She stated that she had nowhere else to go. Ms. Fitzgerald informed Ms. Kaplin that she was not to be alone with her children because of the safety plan. Per the contact note, the CPS told the mother that she would attempt to contact the children's father for a possible placement but that she would take protective custody if he was unable to take the children.

Due to Ms. Kaplin's violation of the safety plan and risk of harm to Yvette and Yvonne, CPS Fitzgerald took protective custody of the children. Investigator Fitzgerald contacted Mike Yaussy, who identified himself as the father of Yvette and Yvonne Kaplin. Ms. Fitzgerald informed Mr. Yaussy that the Department had taken protective custody of his daughters and a hearing would take place at Juvenile Court. Mr. Yaussy informed the investigator that he would be unable to attend the court hearing as he was recuperating from a stroke. When asked if he would be able to take custody of the children, Mr. Yaussy responded that he lived with his mother and would have to discuss the situation with her. Mr. Yaussy did not appear at the hearing and the Department was granted temporary custody of the children.

[30] Ms. Kaplin was under arrest from 11:10 p.m. the day of the incident until 10:51p.m. two days later. Police later rearrested Ms. Kaplin three days later and released her in two days.

Victim Sensitive Interviews (VSI) were conducted with Yvette and Yvonne. Initially, Yvonne stated that Vincent pushed Sierra down and that her sister Yvette hit Sierra with a basketball. Later in the interview, Yvonne said that Sierra made Ms. Kaplin angry and that her mother shook the child. Sierra began crying and Ms. Kaplin told the child that she was sorry then held her. Yvonne stated that she was in the same room when the incident occurred. She added that Sierra was hit with the basketball and pushed by Vincent after Ms Kaplin shook her. In a separate VSI, Yvette said that she saw her mother lift Sierra by her foot and arm and throw the child onto the carpeted living room floor twice. Yvette told the interviewer that Sierra began to bleed after she was thrown to the floor and that Anisha Valdes arrived after she, her sister, and Ms. Kaplin began cleaning Sierra. According to the detective's notes of the VSI, Yvette stated, "Sierra was laying in bed and we didn't want Anisha to know Sierra was hurt."

In the Child Protective Services report, Dr. Ava Jepson wrote that Sierra sustained severe brain swelling which indicated that several hours elapsed before Ms. Kaplin sought medical attention. According to Dr. Jepson, "[Sierra's] demise is directly related to not only the injury but the delay in seeking care."

Ms. Gould was indicated for Death by neglect (Allegation #51) and Head Injuries by neglect (Allegation #52) to Sierra. Joan Kaplin was indicated for Death by abuse (Allegation #1) and Head Injuries by abuse to Sierra (Allegation #2), and Substantial Risk of Physical Injury to her daughters Yvette and Yvonne (Allegation #60). Ms. Kaplin has been charged with first-degree murder and is awaiting trial. She has been released on bail. Her daughters Yvette and Yvonne are currently in foster care.

ANALYSIS

Investigative Deficiencies in SCR# 99-A

The investigation suffered from a general failure to investigate. The investigator never firmly established when, where, and how Sierra was said to have fallen and never determined a credible etiology of Sierra's injuries.

Moreover, the investigator failed to conduct a thorough investigation according to Rule and Procedure 300, blatantly disregarded Philip Lexington's parental rights, and circumvented the orders of medical professionals as to follow-up care for Sierra.

Bruising

Sierra presented with facial bruising that was highly suggestive of abuse, absent a clear and consistent explanation for it. The bruising was observed by the father, paternal grandparents, hospital staff, the DCP mandate worker and CPS Melody Poole, herself. The photographs taken at West Hospital reflect stripes, suggesting a slap applied with significant force. The attending physician, Dr. Corey Tyson, opined that the injury appeared to be a slap mark and that the caretaker/babysitter's explanation that a pacifier caused the injury was not consistent with the bruising. The babysitter gave the pacifier explanation to the infant's mother and father. While minimizing the extent of Sierra's injury to the investigator ("two little scratches"), the babysitter maintained an injury from the pacifier, but denied there were any bruises. She said that perhaps the bruises came from falls in her home. Through observation, the investigator ruled out the pacifier account. She also identified no furnishings or objects in the home that would have left the linear-patterned injury. The investigator's rationale for unfounding the investigation stated:

> Although Sierra was observed with bruises on her face by CPS, natural father, attending doctor and social worker; there is no credible evidence to support how minor received the injuries based upon statements by Dr. Corey Tyson, and household members to include

> natural mother, Ms. Tara Gould, babysitter, Ms. Kaplin, her daughters and landlord who reportedly observed no bruises. Therefore, the allegation is unfounded.

This rationale is simply inconsistent with the facts. The father reported to multiple sources (hospital, mandate worker, investigator) that when he picked his daughter up her face was bruised and he asked Ms. Kaplin what happened. Ms. Kaplin told him the bruising was from the child's pacifier. When the child appeared to be in discomfort, the father got worried and took her to the hospital where the attending doctor saw the bruise, said it appeared to be a slap mark, and said that a pacifier causing the injury was inconsistent with the injury. Later, the investigator noted that the doctor could not make a clear determination whether the bruises were the result of physical abuse. He said the injuries might have been accidental or caused by falling, but not by a pacifier. He suspected abuse because the pacifier story was false, and there was no other clear explanation for the bruises.

To indicate the case, the investigator simply needed to determine that abuse to Sierra by the babysitter was more likely than not. The facts were in accordance with this standard and the doctor was clear in his statement.

During her interview with the investigator, the babysitter said that the only thing she could think of that might account for the bruises she did not observe were two falls: one in the living room and one in the dining room. The babysitter said the falls were witnessed by her daughters and four other children who lived in the building. One of the twins said the falls occurred the day before Sierra was picked up by her father. The other twin made no mention of the falls in her interview with CPS Poole. The investigator told OIG investigators that she observed the areas where Sierra was reported to have fallen and did not view or identify any objects or furnishings that could have caused injuries to the child's face. Regardless, she should have interviewed the other witnesses who could have provided further corroboration that falls were not responsible for Sierra's bruised face.[31]

The investigator used Wanda Stack, the building landlord, as an "Identified Witness (knowledge of incident)" though neither Ms. Kaplin nor her daughters identified Ms. Stack as a witness of Sierra's alleged falls. In her interview of Ms. Stack, the investigator should have solicited additional contact information for the children who were reported to be present at Ms. Kaplin's home at the time of the incident.

Bias against the father

The investigator's bias against the father in this case likely affected her decision-making. Instead of indicating the investigation based on the facts, she speculated that the injuries were caused by the father in the three to four hours from the time the father picked up Sierra to the time he took her to the hospital.

Despite the father's care of his daughter, diligence in seeking her medical care, intent to take her to her follow-up appointment, and unease in returning her to her mother, the investigator insisted upon the

[31] Procedure 300 states "In addition to the required contacts with the subjects of the report, other persons in the household, law enforcement agencies, and the State's Attorney's Office, the Department has established other minimum investigative contacts for each allegation that are required before the investigation can be considered completed." (Procedure 300 Section 300.60 f) Other Required Investigative Contacts, emphasis by OIG.) In a formal investigation of Cuts, Bruises, Welts, Procedure 300 requires that a child protection service worker interview all identified witnesses who are reported to have knowledge of the incident that resulted in cuts, bruises or welts. The allegation also specifies that a waiver of any of the required contacts must be given by the supervisor and documented on a SACWIS Case Note.

mother taking her child (and accompanying her to do so) from the father' safe home to a home where she had been injured.

The investigator's contact notes and statements during the OIG interview reveal that her disposition toward the father was based on a number of presumptions:

- The investigator believed Ms. Gould to be Sierra's sole custodial parent, though according to her own investigation notes, both parents agreed that they shared custody. In addition, Sierra's belongings were at the father's home, the child did not have a bed at Ms. Gould's residence, and when visiting, Sierra usually slept with Ms. Kaplin and her ten-year-old daughters.

- The investigator told Sierra's father and parental grandparents that only Ms. Gould could consent to medical attention for Sierra.

- The investigator misinformed involved family members that the mother's rights superseded the father's rights.

- Mr. Lexington informed the investigator that Ms. Gould frequently neglected to check on Sierra when the child was in his care. The investigator's bias was apparent early on when she worked to get the mother to visit Sierra in the hospital instead of integrating the information which suggested the lack of visitation was a lack of interest in the child.

DCP Investigation SCR# 100-A

Joan Kaplin told CPI Tennika Jones that 12-month-old Tatiana Camden sustained a serious head injury while she allowed the child and Sierra to play unsupervised. The investigator and her supervisor, Zebretta Williams, were both aware of the prior investigation in which Sierra sustained injuries while Joan Kaplin babysat. Although Ms. Jones expressed her concern for Sierra's safety to Ms. Gould, the investigator failed to add Sierra as an alleged victim of both inadequate supervision and substantial risk of injury (neglect). While Ms. Kaplin was indicated for inadequate supervision of Tatiana, she was not investigated with regard to Sierra though both children were in the same room when Tatiana was allegedly injuried while unsupervised.

Though Dr. Jepson provided the investigator with an MPEEC report and offered the assistance of West Hospital Child Protective Services, there was no evidence to suggest that the investigator conferred with Dr. Jepson following their initial phone discussion or that the investigator and supervisor consulted with Detective Graham regarding the police investigation findings.

***Notifying involved fath*ers**

The investigator and supervisor were aware that Sierra had a father who was very involved in her life. They should have notified him that another child was hurt in Ms. Kaplin's home only a month after the conclusion of the investigation involving Sierra. While Sierra's mother agreed to find alternate childcare for Sierra, the likelihood that Ms. Kaplin would have access to Sierra was high. As Sierra and her mother lived with Ms. Kaplin, it was easy to leave Sierra at home with Ms. Kaplin, and the mother did not believe that Ms. Kaplin hurt either her daughter or Tatiana. Had Sierra's father been advised of the investigation, he may have provided extra protection for her. In addition, Ms. Kaplin's agreement to discontinue babysitting Sierra would not be monitored once the investigation was closed. Despite having read the prior investigation, which indicated that Mr. Lexington was an involved father, Investigator Jones and PSA Williams ignored him during the May 2007 investigation pertaining to Tatiana Camden.

Notification of the Investigation Findings to Mandated Reporters

While notices of investigation findings sent by child protection comply with Rule 300, notifications to mandated reporters generated by the SCR do not contain the name of the alleged child victim as required by Rule. The Department must ensure that notices from the SCR conform to Rule 300.130.