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Office of the Inspector General

REDACTED REPORT

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OIG No. 020161
Minor: Logan Wagner – 4/00 – 8/01
Subject: Death Investigation

I. Summary of Complaint

Logan, 16-month-old, and his mother, Tanya Conway, died from injuries sustained after a fire broke out in their apartment at 9:30 in the morning in August 2001. Ms. Conway, who had been indicated by the Department three times for substance misuse, had been receiving intact family services and her case had been closed two months prior to the fire. According to an SCR report called in by the Medical Examiner's office, two of Ms. Conway's children were playing with matches in the living room, which caught on fire while their mother was in her room asleep. The Medical Examiner concluded that Ms. Conway and her son died from smoke inhalation and that Ms. Conway tested negative for alcohol, cocaine, and opiates.

II. Investigation

Ms. Conway, who was twenty-nine years old at the time of her death, was the mother of the following six children:

Ricky Conway - 06/25/88
Charles Stuart - 11/20/90
Selena Stuart - 09/29/92
Shane Conway -10/29/95
Valerie Conway - 09/6/97
Logan Wagner - 04/22/00

After the birth of each of her last three children, Ms. Conway was indicated for substance misuse. Two of the children, Shane and Valerie, had been born drug exposed, and the last child, Logan, had withdrawal symptoms although he did not test positive for drugs. Ms. Conway tested positive for opiates at the time of Logan's birth. A LEADS done by the OIG shows a history of drug related charges: Ms. Conway was convicted in November 1994 for drug possession, given 15 months probation, violated probation in February 1995 and was sentenced to the Department of Corrections where she served from September 1996 to November 1996. She was arrested in July 1996 on another drug charge and received probation, which ended in March 1998. She was arrested in March of 2000 on drug related charges that were later dismissed. In May of 2000 she was arrested for possession, and ordered to have a drug assessment, and a warrant for her arrest was issued in September 2000.

First Intact Family Case- November 1995 to June 1998

The Department opened the first intact family case in November 1995 after Shane tested positive for opiates at birth. Although unable to locate the old case record, the OIG investigator spoke with the intact family services worker who serviced the case. The worker recalled that Ms. Conway disappeared for a while and the worker was unable to offer her services. When she finally located her, Ms. Conway was pregnant. Ms. Conway gave birth to her second substance-abused infant, Valerie Conway, in September 1997. Valerie was born positive for opiates (C Sequence) .[1] According to a case note in the DCP report, Ms. Conway was in a methadone maintenance program. Ms. Conway told the DCP investigator she had started the treatment program two weeks prior to the baby's birth and she had used heroin because the clinic was closed and she had been unable to obtain her methadone dosage.

Treatment records from the methadone maintenance program document that Ms. Conway was admitted to a methadone treatment program on August 16, 1997. Ms. Conway attended counseling sessions during which she expressed frustration with her living situation, which included living with other adults who used drugs around her children. Ms. Conway was also bothered because none of the adults, including her mother, helped with expenses. The counselor noted that Ms. Conway appeared to be "visibly frustrated and overwhelmed with the situation of supporting her mother and the mother's boyfriend" and that she had difficulty confronting her mother about their living conditions.

Ms. Conway initially received 35 mg. of methadone in August 1997. Her dosage increased to 80 mg. in February 1998. According to laboratory reports, Ms. Conway tested positive for opiates and methadone in August, September, October, and November 1997 and January 1998. Ms. Conway tested positive for opiates, cocaine, and methadone in March 1998 and on June 25, 1998.

The Department closed Ms. Conway's case on June 8, 1998. The intact family services worker could not recall where Ms. Conway had her treatment or much of Ms. Conway's treatment history. She said when she closed the case in June 1998, Ms. Conway had completed treatment. Ms. Crawford told the OIG investigator she was sure there were records documenting that Ms. Conway had completed treatment because she would not have been able to close the case

[1] The "B" sequence was unfounded.

without such documentation. According to the worker, Ms. Conway's mother was living with her and helping her care for the children. The worker described Ms. Conway as a "functioning" mother who took good care of her children: she said there was always food in the home, the apartment was always clean, and the children attended school. Documentation obtained by the OIG investigator shows that the school age children have had few absences from school.

Although the Department closed Ms. Conway's case, she continued to be involved in the treatment program. Individual progress notes indicate that Ms. Conway met with staff in October and November 1998 (she also missed an appointment in November 1998), and April and May 1999. Laboratory reports contained in the treatment program records show that Ms. Conway tested positive for opiates, cocaine and methadone in December 1998 and February and April 1999. In June 1999, Ms. Conway asked to enter a detoxification program. A physician's order sheet also reflects a request for detoxification. A note from September 1999 states that she was reinstated and received a methadone dosage of 80 mg. On October 20, 1999, Ms. Conway was discharged from the program. The records do not state the reason for the discharge.

Second Intact Family Case- June 2000 to June 2001

Ms. Conway's second case with the Department opened after she was indicated on June 6, 2000, for substance misuse after Logan was born. The case was assigned to DCFS intact family worker Betty Perry.[2] The supervisor on the case was Lakisha Tomlin. Ms. Perry visited the family on June 9, 2000. According to case entry notes, Ms. Conway explained that she had completed a drug screen and she was going to contact that agency to find out if space was available for her and her children. Ms. Perry visited Ms. Conway again in July 2000. Because Ms. Conway had been unable to find someone who would take care of her younger children (Shane, Valerie, and Logan) during treatment, Ms. Perry told her she would look for a place that would provide treatment and daycare for her children. Although it is not entirely clear from the case notes, it appears that only four-year-old Shane, two-year-old Valerie, and two-month-old Logan were living with their mother and that the three older children were residing with relatives.

When Ms. Perry visited Ms. Conway's home on July 20, 2000, a friend of Ms. Conway told her Ms. Conway had left. The supervisor, Ms. Tomlin, conducted a 45-day review of the case on July 21 in which she noted Ms. Conway's long substance abuse history, a referral to a treatment center, her criminal activity that resulted in her imprisonment, and her disappearances. In August and September 2000, Ms. Perry was able to contact Ms. Conway's son, Ricky, who was residing with his aunt and uncle, Charles and Selena, who were residing with Charles' paternal aunt, and Logan, who apparently had been left with his paternal grandmother by Ms. Conway. There was nothing in the case file indicating where Shane and Valerie were residing.

Ms. Tomlin completed a quarterly review on September 25, 2000, in which she noted that Ms. Conway's location was unknown and that she was not engaged in services. From September through December 5, 2000, Ms. Perry attempted to locate Ms. Conway. At one point Ms. Conway called Ms. Perry and gave her a new address, but Ms. Perry was unable to find her at

[2]Ms. Perry left the Department in December 2000.

that address or at other addresses that had been given to her. Case notes state that Ms. Conway had a scheduled appointment at a drug-screening agency on October 26, 2000, but there is no documentation in the case file indicating she attended the appointment.

Ms. Perry spoke with Ms. Conway on December 5, 2000. According to the case notes, Ms. Conway said she was ready to begin in-patient treatment. Ms. Perry spoke with staff from a treatment program who said they could provide treatment and the children could live with their mother. Ms. Perry gave the information to Ms. Conway who said she would call the intake worker at this treatment program. This was the last telephone conversation Ms. Perry had with Ms. Conway. On December 6, Ms. Tomlin had another quarterly review and noted that the case was going to be transferred to a new worker, Jackie Barry.

On December 20, 2000, June Mercer-Stuart, the paternal aunt to Charles and Selena, called Ms. Lakisha Tomlin, the supervisor on this case. Ms. Mercer told Ms. Tomlin that the children were not living with Ms. Conway and that Ms. Conway still was not in treatment. Ms. Mercer gave her the names and addresses of all the caretakers. Ms. Tomlin noted in the file that a new worker, Jackie Barry, had been assigned to the case and that she was to see the client within 5 days to do a CERAP, assess the school care plan, and engage mother in services.

The following day, December 21, 2000, Ms. Tomlin received another call from Ms. Mercer. According to Ms. Tomlin's case note, Ms. Mercer reported that Ms. Conway was high on drugs and alcohol and that she had taken the children from Ms. Mercer's home. According to the case notes, Ms. Mercer told Ms. Tomlin that Ms. Conway was upset with her because she was trying to obtain food stamps on behalf of the minors who were in her care, and Ms. Conway thought she was entitled to the benefits. Ms. Mercer was concerned because Selena had complained that one of the males in Ms. Conway's household had tried to touch her inappropriately. She also was concerned that the children would not be going to school if they remained with their mother. According to Ms. Mercer, two of the children had never lived with their mother, and they were upset because they had to leave Ms. Mercer's home. Ms. Tomlin told her she should call the hotline if the children called and complained of abuse and she was unable to contact either the worker or herself. Ms. Tomlin also told her the worker would contact Ms. Conway and the children within five days. There is nothing in the case notes indicating the worker or the supervisor ever called the hotline with the information provided by Ms. Mercer.

There are no case entries in the file from December 21, 2000, until April 6, 2001, when the new worker, Jackie Barry, notes that she sent a letter to Ms. Conway's last address. Ms. Tomlin told the OIG investigator that she did not know whether Ms. Barry visited the family during this four-month period. The next case entry indicates that Ms. Barry visited the family on May 10, 2001, and observed four of the children, Ricky, Selena, Shane, and Valerie who appeared "well bonded" with their mother. According to Ms. Barry's notes, Ms. Conway said she had completed a methadone maintenance program and had been clean for six months. Ms. Barry wrote that they discussed an after care plan which included attending AA and NA meetings and maintaining a drug free life style. Contrary to Ms. Conway's self-report, treatment records show that they discharged Ms. Conway from their treatment program in October 1999, two years prior to Ms. Conway's most recent indicated report for substance misuse. There were no more recent treatment records in Ms. Conway's file.

Ms. Barry visited the family again on May 18, 2001. According to her notes, Ricky, Selena, Shane, and Valerie were in the home and "appeared comfortable in their present environment." Ms. Conway told her she was attending AA, however there is nothing in the file indicating that Ms. Conway had provided Ms. Barry with AA attendance sheets or her sponsor's name.

On May 18, 2001, Ms. Tomlin held a supervisory conference with Ms. Barry. In a supervisory case note, Ms. Tomlin wrote that the worker should, among other things, obtain the name of the counselor Ms. Conway had seen at the methadone maintenance program, obtain documentation showing that Ms. Conway had completed treatment, get a release of information from Ms. Conway, schedule Ms. Conway for a urine drop, obtain medical information on the baby, find out if Ms. Conway had attended AA and when and where, and document this information prior to closing the case. Again, there are no records either in the case file or received from the methadone maintenance program documenting any treatment for Ms. Conway subsequent to her discharge in October of 1999.

Ms. Barry's last visit with Ms. Conway was on May 29, 2001. Ms. Conway told her she did not recall the name of her counselor and that she had last attended sessions in January 2000. Ms. Barry gave Ms. Conway a urine drop voucher. In the last case entry in the file, Ms. Barry wrote that she had called staff who told her that Ms. Conway had not attended her appointment scheduled for May 30, 2001.

Although Ms. Barry prepared a closing summary on May 7, 2001, the case was actually closed on June 7, 2001, by Ms. Tomlin. A closing summary signed by both Ms. Barry and Ms. Tomlin notes that although Ms. Conway had not shown proof of completion of services, the children appeared safe.

Interview with Supervisor, Lakisha Tomlin

In an OIG interview, Ms. Tomlin acknowledged that she had not supervised the case well. According to Ms. Tomlin, a number of personal problems occurred during the time she was supervising this case. She especially relied on Ms. Barry because she was the lead worker of the team, had an MSW, and had in the past been assigned as the temporary supervisor on her team. Ms. Tomlin admitted that she had closed out the case without verifying that Ms. Conway had completed treatment, again trusting that Ms. Barry had obtained the necessary documentation.

The Fire

According to the CANTS 1 report called in by the Medical Examiner, three children, Logan, Valerie, and Shane, were in the living room and Ms. Conway was in her room asleep. Five-year-old Valerie was playing with matches which fell on a couch or mattress after she tried to throw them out the window. Ms. Conway tried to get water out of the bathroom, but collapsed in the hallway. The Fire Department was called at 9:30 a.m. The Fire Department's report states that there was no smoke detector in the apartment; however, according to newspaper accounts, officials from the housing authority said they had a statement signed by the tenant, apparently Ms. Conway's boyfriend, in April 2001 in which he acknowledged that an alarm had been

installed in his apartment. Neither the police department nor the fire department investigated the matter further.

III. Analysis

Supervisor's Performance

Jackie Barry, and her supervisor, Lakisha Tomlin, were negligent in carrying out their responsibilities to Ms. Conway and her family. Subtracting the two months in which Ms. Tomlin worked less than five days, Ms. Tomlin still worked an average of 18 days a month during the time that she was responsible for this family.[3] Furthermore, during the time that Ms. Tomlin was responsible for this case, she supervised an average of six workers who carried an average of ten cases. Ms. Tomlin's small caseload and the amount of time she was in the office make her performance in this case woefully inadequate. The caseworker and supervisor have since left the Department.

Intact Services for Families with Substance Exposed Infants

The Department needs to ensure that families in which there is a substance-exposed infant receive intensive targeted intact family services that specifically address the needs of a parent with a substance abuse problem. Rather than specialized casework services, many families receive generic intact services, minimal face-to-face contact and their cases are closed in a year or less. For example, a Cook North – Intact Family Special Review completed by the Department of Quality Assurance, March 2002 revealed that only 65% of intact family caseworkers visited their clients and clients' children for the minimum monthly contact. The acting Director of Quality Assurance stated that this minimum monthly contact comes from Council On Accreditation (COA) requirements. However, according to the Deputy Director of the Division of Child Protection and the Associate Deputy Director, the current expectation is that Department workers visit families weekly, unless their supervisor approved fewer visits. The Department's current Child Protective Services program plan for POS intact service programs also requires a minimum of weekly in-person contacts with involved family members.

An SEI birth indicates that the mother's substance abuse problem is serious because the mother has been unable to refrain from using during her last trimester of pregnancy. Workers gave Ms. Conway referrals for treatment yet no one accompanied her to ensure that she followed through with treatment. She underwent drug screening, but no one held her accountable when her drops were positive. There were no consequences for her failure to complete treatment. Mothers who serially give birth to drug exposed infants require intensive services that effectively address their drug addiction. Intact family caseworkers should aggressively seek services; monitor treatment compliance and progress, and have more than one contact per month. The need is even greater when a caseworker is presented with a mother like Ms. Conway who had three preschool children making it even more challenging for her to complete all the necessary requirements to complete treatment

[3] This amount was determined by averaging the days Ms. Tomlin worked between June 6, 2000, when she received the case, and August 6, 2001, when Logan died.

By the time Ms. Conway had her third SEI, her family had undoubtedly been exposed to the chaos that generally accompanies a drug lifestyle. Ms. Conway's long history of substance abuse, her failed attempts at treatment, and her criminal history resulting in incarceration all indicated that this case should have been handled differently. Although offered services, Ms. Conway never successfully completed any substance abuse treatment program. Without any leverage and no appropriate consequences for their failure to comply with services, mothers such as Ms. Conway will continue to abuse drugs and children will continue to be at risk.

In Ms. Conway's case, fatal casework errors included lack of accountability for her treatment compliance, over-reliance on her self-reports, failure of communication between drug treatment providers and child welfare caseworkers, no home safety checks and a lack of instructional interventions on basic family health and safety. Ms. Conway never completed drug treatment, continued to have positive multi-drug urine drops, and received only intermittent child welfare services. A concerned aunt was not drawn in to help. At the time of Ms. Conway and Logan's death, there was no smoke alarm in the house.

Review of Data Regarding Substance Exposed Infants

Because of the intensity and depth of problems presented by the Wagner case, the OIG attempted to determine if the problems were specific to this case or generalized across cases. Ms. Conway's first SEI child was born in FY 1996. Prior to FY1997 DCFS did not keep detailed administrative records of child protection cases. The OIG investigators conducted a detailed examination of the available child protection data from FY 1997 through FY 2002. The OIG review found that during that time period 232 mothers had given birth to at least three substance-exposed infants. The startling finding of this investigation was the number of children involved. While the typical DCFS family size, according to ACR data, is three children and the average TANF family is two children, the 232 families in this data set had over 1,600 children ranging in family size from 3 to 14 children. The average size of these families is approximately seven children. The mothers' ages range from 20 (with three children in placement) to 45 (with 12 children in placement). Ms. Conway, who has six children, was 29 when her third SEI was born; she had her first child at 16. Of the 1,600 children, at least 700 were born substance exposed. It is safe to assume that the remaining nine hundred children were exposed to high-risk drug lifestyles. Presently, 21 of the 232 families (almost 10%) have split cases with some children in state custody and others remaining in the home of a parent.

Safety Issues

Both Ms. Conway and her son, Logan, died in a fire in their home. Their deaths might have been prevented if the apartment had a functioning smoke detector. The newspaper reported that of the 44 people who died in fires in 2002, " non-working smoke detectors were discovered in more than 95% of the … fires". The paper is quoted to say: "Fire kills mother, 2 year-old" …December.., 2002. According to Federal Emergency Management Agency (FEMA), "approximately 28 of every 1,000 fires are caused by children playing with fire… Younger children, birth through 4 years, who are less able to seek safety, are at significantly higher risk than older children, age 5 through 9. African American children face inordinate fire risks relative to white children."

Currently the Department does not have a policy requiring workers to check for safety hazards prior to closing an intact family case. It is important that intact families be aware of environmental hazards in their homes. Parents whose main focus has been on obtaining drugs might be less aware of environmental hazards and not as attentive to safety issues within the home. Moreover, because these parents typically have limited resources, their physical environment can pose dangers. It is therefore important to assess home safety in a way that will alert the parent to potential safety hazards in the home. Of the 200 children's deaths that were reported to the OIG in the last two fiscal years, 15 were the result of house fires. In an effort to prevent future fire deaths, the Department should implement home and fire safety trainings in intact cases.

OIG Best Practice initiatives and the States' Death Review Teams have recommended home and child interventions. Current data from the Intact Family project (IFR) demonstrate the increased home safety through the use of the substance abuse recovery guide as well as the home safety checklist. 73% of the families served by IFR teams were able to remain in a safe and healthy home. Of the 375 families served by IFR, there were no fire deaths.

IV. Recommendations

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

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

3. Many children die or are injured as a result of fires in the home which could be prevented by appropriate safety measures. It is unclear whether there was a functioning smoke detector in Ms. Conway's apartment when the case was closed on June 7, 2001. However, if the worker had completed a home safety check with the mother before she closed the case, this tragedy might have been averted. The OIG has developed a home safety checklist that is being used in the Intact Family Recovery project. Included in the list of safety items to check is ensuring that the home has a functioning smoke detector. The Department should use this safety tool for use by intact family workers in substance abuse cases. This tool should be used when the case is first opened, when a parent moves to another home, and when the case is closed.

4. All DCP managers must attend the Fire and Home Safety training that will be offered by the OIG.

5. *This recommendation addresses personnel issues and has been redacted.*

6. The Deputy Director of the Division of Child Protection should conduct a record review to insure that intact case managers are complying with the current expectation that families are visited on a weekly basis.