Office of the Inspector General

Illinois Department of Children and Family Services

Annual Report to the Governor & the General Assembly

Fiscal Year 2025
July 1, 2024 - June 30, 2025

Ann McIntyre
Inspector General

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

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To Governor Pritzker and Members of the General Assembly:

I respectfully submit the Fiscal Year 2025 Annual Report of the Office of the Inspector General for the Department of Children and Family Services.

For over 30 years, the Office of the Inspector General (OIG) has been committed to the mission of strengthening the child welfare system through independent investigations that identify areas for reform and hold the Department, its employees, and contracted agencies accountable. This FY 2025 Annual Report contains the summaries of the 20 investigative reports submitted to the Director in FY 2025 and details the Department's responses and implementation plans for the 61 recommendations issued. Recognizing the complexities of the child welfare system, the OIG issues both case specific and systemic recommendations to strengthen the system charged with protecting our most vulnerable children and families.

The Department continues to demonstrate a commitment to implementing the recommendations issued by the OIG. To date, the Department has implemented 42 of the 61 recommendations made in FY 2025 and has submitted an implementation plan for the pending 19 recommendations. The OIG will continue to monitor the Department's implementation of the recommendations issued in FY 2025 as well as the pending recommendations from prior fiscal years. This fiscal year, the OIG monitored the implementation of 73 systemic recommendations pending from prior fiscal years, 35 of which are pending in part due to the Department's implementation of the new safety assessment tool, SAFE Model, and the new technology information system, IllinoisConnect. The SAFE Model and IllinoisConnect will address many prior recommendations related to safety planning and technology improvements. Where feasible, the Department has begun deploying interim practice improvement measures and front-line guidance to address recommendations until the systems are fully implemented. (See Department Update on Prior Recommendations, page 117.)

In FY 2025 the OIG launched a new case management system to enhance office operations. The new system was designed to improve accessibility by allowing complaints to be filed through an online portal, streamline the intake process for increased efficiency, centralize investigation records to support productivity, and strengthen monitoring of the implementation status of recommendations issued to the Department.

I am grateful to the Governor for the opportunity to serve as the Inspector General of the Department of Children and Family Services and it is with heartfelt appreciation that I recognize my team for their unwavering commitment to the mission of this office and the children and families of Illinois. Acknowledging the many challenges of a complex and demanding child welfare system, I also recognize the dedicated child welfare professionals throughout Illinois who work tirelessly to ensure the safety of children and provide services to families.

Respectfully,

Ann McIntyre
Inspector General


Illinois Department of
DCFS
Children & Family Services

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INTRODUCTION

The Office of the Inspector General (OIG) of the Illinois Department of Children and Family Services (Department or DCFS) was created in 1993 to reform and strengthen the child welfare system. The statutory mandate of the OIG is to investigate misconduct, misfeasance, malfeasance, and violations of rules, procedures, or laws by DCFS employees, foster parents, service providers, and contractors with the Department (20 ILCS 505/35.5 – 35.7). To that end, the OIG conducts independent, comprehensive investigations and issues recommendations to protect children, ensure accountability, improve practice, and support professional growth within the child welfare system.

The Inspector General submits investigative reports to the Director of the Department and to the Governor. Investigations yield both case-specific recommendations, including disciplinary recommendations, and recommendations for systemic changes within the child welfare system. The OIG issues recommendations to the Director of the Department and, if applicable, to the Director and Board of the involved child welfare contributing agency (CWCA). When recommendations concern a CWCA, appropriate sections of the report are provided to the Administrator and the Board of Directors of that agency. The agency submits a response to the report when necessary and may meet with the Inspector General to discuss the report and recommendations. The OIG monitors implementation of recommendations made to the Director of the Department and CWCAs.

The OIG's investigative process begins with a Request for Investigation, notification of a child's death or serious injury, or a referral for a Child Welfare Employee Licensure investigation. Rules of the Office of the Inspector General are published in the Illinois Register at 89 Ill. Adm. Code 430. The Rules govern intake and investigations of child deaths, serious injuries, and complaints of misconduct. Requests for investigation and notices of deaths or serious injuries are reviewed to determine whether the facts alleged suggest possible misconduct or identify a need for systemic change. If warranted, the OIG will conduct a full investigation pursuant to 89 Ill. Adm. Code 430.

A complainant to the OIG, 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. However, if the complainant does not provide enough information, the OIG may not be able to pursue the investigation. 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.

The OIG utilizes investigative findings as the basis for Error Reduction Training to remedy patterns of errors or practices that compromise or threaten the safety of children pursuant to 20 ILCS 505/35.7. Redacted reports may also be used as a resource for child welfare professionals, providing a venue for supervisory and ethical discussions on individual and systemic problems.

General Investigations

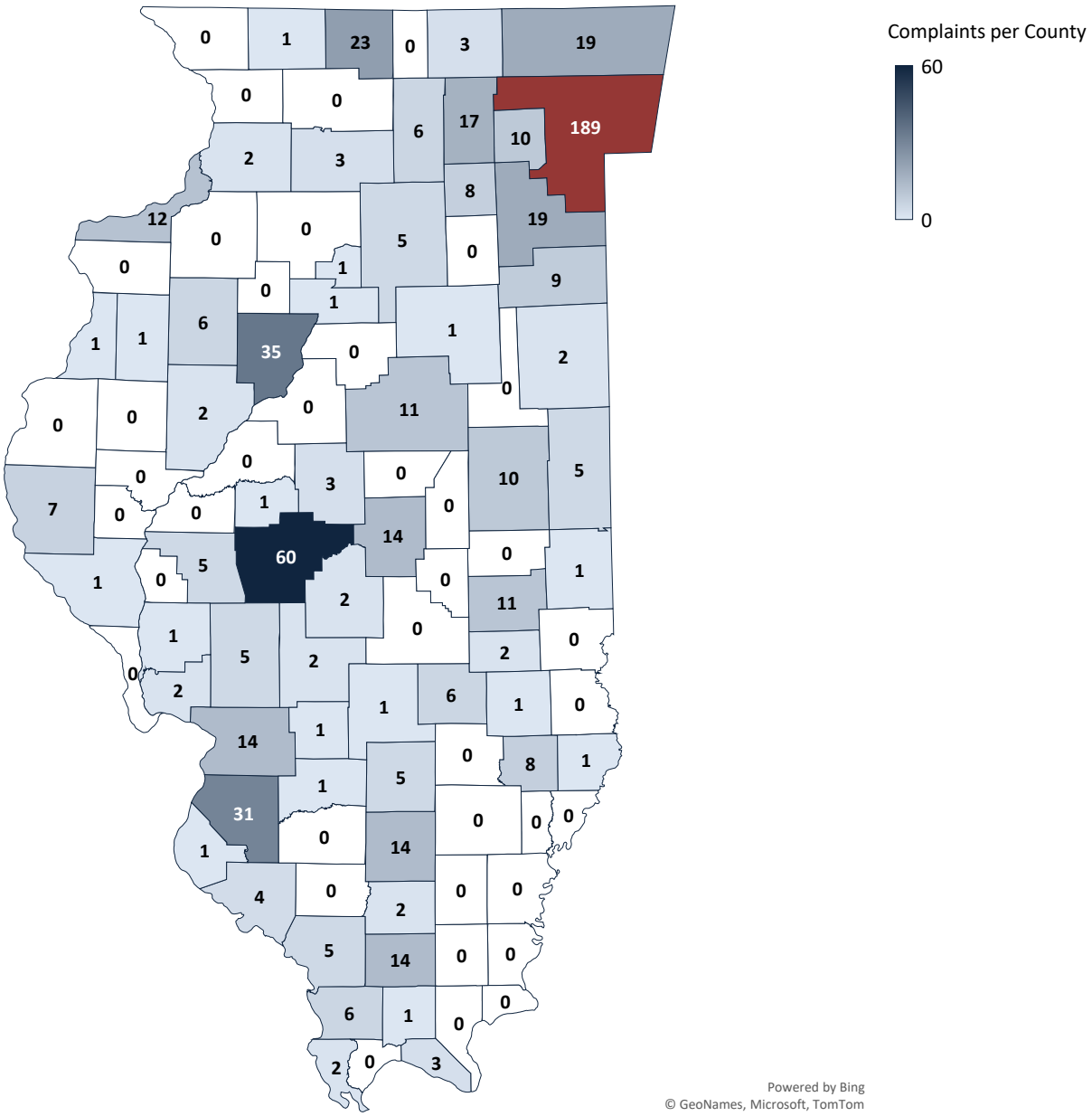
A Request for Investigation may be filed by the state and local judiciary, Department and Child Welfare Contributing Agency (CWCA) employees, law enforcement, other state agencies, medical providers, foster parents, biological parents, relatives, and the public. The OIG also receives referrals from the Office of Executive Inspector General (OEIG). Following review, a request for investigation may be opened for investigation or incorporated into an existing OIG investigation, closed, or referred as appropriate to law enforcement, Department management, the Division of Diversity, Equity, and Inclusion, DCFS Labor Relations, the Advocacy Office for Children and Families, and other regulatory agencies.

In FY 2025, the OIG received 762 requests for investigation and 191 OEIG referrals, totaling 953 complaints.

FY 2025 Complaints	
Requests for Investigation	762
OEIG Referrals	191
Total Complaints Received in FY 2025	**953**

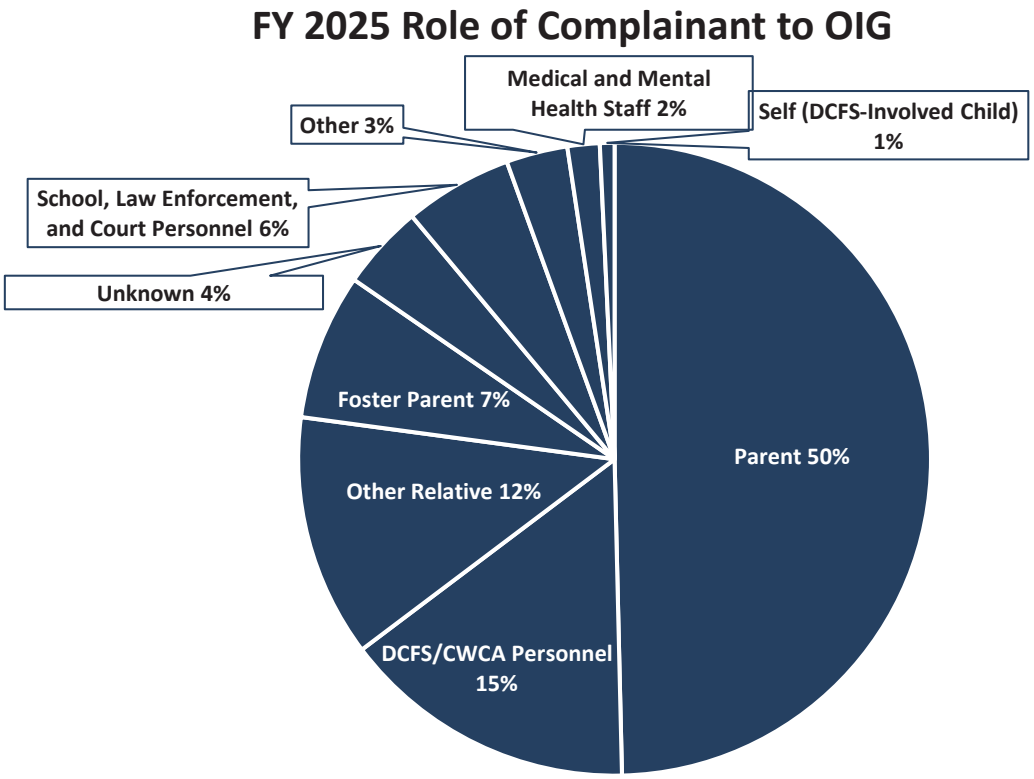
In FY 2025, of the 953 complaints received, the OIG opened 669 general investigations. The map below illustrates the location of subjects of OIG general investigations who were employed by DCFS and CWCAs throughout Illinois.

FY 2025 OIG General Investigation Subject Locations



*This map does not include investigations regarding systemic or state-wide issues, investigations where the subject location could not be identified, or investigations where the individual was determined to be outside the OIG's investigative jurisdiction.

The OIG accepts requests for investigation from multiple sources. In FY 2025, 50% of general investigations opened originated from a request for investigation by a parent. See below chart of the role of complainants for FY 2025.



See page 95 for summaries of general investigations resulting in an investigative report submitted by the Inspector General to the DCFS Director in FY 2025.

Child Welfare Employee Licensure

In 2000, the General Assembly mandated that the Department institute a system for licensing direct service child welfare employees, including Department and CWCA investigative, child welfare, and licensing workers and supervisors. Rules pertaining to employee licensure action are found at 89 Ill. Adm. Code 412. The OIG is tasked as the investigative body and Department representative for prosecution of Child Welfare Employee Licensure (CWEL) complaints.

In FY 2025, 97 cases were referred to the OIG for CWEL investigations.

FY 2025 CWEL Investigation Referrals and Dispositions	
Pending	37
Closed Pre-Licensing Investigation	33
Closed Monitoring of an SCR Report	15
Closed CWEL Investigation, No Licensure Action	8
Closed, CWEL Voluntarily Relinquished	4
FY 2025 CWEL Investigation Referrals Received	**97**

See page 7 for further information on CWEL.

Deaths and Serious Injuries

The Inspector General investigates the death or serious injuries of a child when there was an open child welfare service case or child protection investigation within one year of the death or serious injury. (89 Ill. Adm. Code 430.30) The OIG maintains a database of child death statistics and information related to child deaths as reported to the OIG. In FY 2025, OIG received 611 notifications regarding the deaths of 540 children, a number consistent with recent years. 163 of those deaths met criteria for OIG review. Twenty-two of the 163 children were youth in care at the time of death. Deaths are classified in five manners, as determined by coroners, medical examiners, or pronouncing physicians: homicide, suicide, undetermined, accident, and natural. Of the 163 child deaths reviewed, largest categories of manner of death were natural (62 deaths) and accident (37 deaths).

See page 25 for further information and a statistical summary of the 163 child deaths reviewed by the OIG in FY 2025.

FY 2025 Child Death Cases Reviewed	
Investigatory Review of Records	143
Full Investigation	13
Systemic Issue Report	7
Child Deaths in FY 2025 Meeting OIG Criteria for Review	**163**

Full investigative child death reports submitted to the director in FY 2025 are summarized in the Investigations section of this report. Full investigative reports submitted in FY 2025 may include deaths in prior years. Of the 13 child deaths opened for full investigation in FY 2025, 12 remain pending. The Investigations section also contains information of all child deaths reviewed by the OIG in FY 2025.

See page 13 for further information on death and serious injury full investigations.

Background Checks and Law Enforcement Liaison

The Department is required by statute to assess the relevant criminal history of caretakers prior to the placement of children (20 ILCS 505/5(v)). The OIG provides technical assistance to the Department in conducting out of state background checks for assessing child safety for placements. Seven OIG staff members are LEADS certified.

In FY 2025, the OIG's LEADS operators conducted 8,065 searches for criminal background information, an increase of more than 200 from FY 2024.

FY 2025 Criminal Background Searches	8065

The Inspector General serves as the primary liaison between the Department and the Illinois State Police. In the course of an investigation, if evidence indicates that a criminal act may have been committed, the OIG shall notify the Illinois State Police. The OIG assists law enforcement agencies with investigations, as requested. Following any criminal investigation, the OIG will determine if further administrative investigation or action is appropriate.

See page 11 for further information on criminal background investigations and law enforcement referrals.

OIG Hotline

Pursuant to statute, the OIG operates a statewide, toll-free telephone number for public access, referred to as the OIG Hotline. (20 ILCS 505/35.6) The phone number for the OIG Hotline is (800) 722-9124.

The OIG Hotline is an effective tool that enables the OIG to communicate with concerned persons, respond to the needs of Illinois children, and address day-to-day problems related to the delivery of child welfare services.[1]

Similar to the OIG Hotline, the OIG operates a General Intake line that fields inquiries from the public regarding requests for investigation and refers callers to other state agencies and DCFS divisions, as appropriate. The phone number for the General Intake line is (312) 433-3000.

In FY 2025, the OIG received 663 telephone inquiries through the OIG Hotline, a 17% decrease from FY 2024. In FY 2025, the OIG screened 1059 telephone inquiries through the OIG General Intake line, an 11% increase from FY 2024.

FY 2025 Telephone Inquiries	
OIG Hotline: Information and Referral	404
OIG Hotline: Referred to SCR Hotline	33
OIG Hotline: Request for OIG Investigation	226
OIG Hotline Total	**663**
OIG General Intake Line	1059
Call Total	**1722**

1 Foster parents, parents, guardians *ad litem*, judges, and others involved in the child welfare system have called the OIG Hotline to request assistance in addressing the following concerns: complaints regarding DCFS caseworkers and/or supervisors ranging from breaches in confidentiality to failure of duty; complaints about private agencies or contractors; Child Abuse Hotline information; child support information; foster parent board payments; Youth in College Fund payments; problems accessing medical cards; licensing questions; ethics questions; general questions about DCFS and the OIG.

CHILD WELFARE EMPLOYEE LICENSURE

In 2000, the General Assembly mandated that the Department of Children and Family Services (Department or DCFS) institute a system for licensing direct child welfare service employees and supervisors (20 ILCS 505/5c and 5d). The direct child welfare employee licensure system permits centralized credentialing and monitoring of all persons providing direct child welfare services, whether employed with the Department or a Child Welfare Contributing Agency (CWCA). The employee licensure system sets licensing standards, qualifications, and training requirements for direct child welfare service employees and maintains accountability and integrity of those entrusted with the care of vulnerable children and families. (89 Ill. Adm. Code 412).

A direct service Child Welfare Employee License (CWEL) is required for Department and CWCA investigative, child welfare, and licensing workers and supervisors. The Department, through the Office of Child Welfare Employee Licensure (OCWEL), administers and issues CWELs. During the licensing process, OCWEL may refer applicants to the Office of the Inspector General (OIG) for a pre-licensing investigation if information in the CWEL application indicates that the applicant has engaged in acts that may be grounds for suspension, revocation, or refusal to reinstate a license as described in Rule 412.50. When referred, the OIG will complete a limited investigation of the applicant and provide investigation findings to OCWEL. If OCWEL determines that the pre-licensing investigation findings provide a basis for refusal to issue a license, OCWEL may refuse to issue a license in accordance with Department Rule 412.40 c).

The Emergency Licensure Review Team (ELRT), a committee composed of a representative from OCWEL, a representative from the OIG, and the Chairperson of the CWEL Board, screens CWEL complaints for referral to the OIG for investigation. The committee reviews all CWEL complaints to determine whether a Rule 412.50 ground for licensure action is alleged. (89 Ill. Adm. Code 412). The OIG investigates CWEL complaints and an OIG attorney, serving as the Department Representative, files administrative charges and manages the prosecution of CWEL cases through the Department's Administrative Hearings Unit (AHU).

Department Rule 412.90 provides that the CWEL Board may preliminarily suspend the license of a direct child welfare service employee without a hearing, simultaneously with the receipt of a complaint that contains sufficient indications of reliability and suggests that the licensee may pose an imminent danger to the public if allowed to continue practicing direct child welfare services pending investigation or licensure action. If requested, a post-preliminary suspension hearing will be scheduled with the Department's AHU.

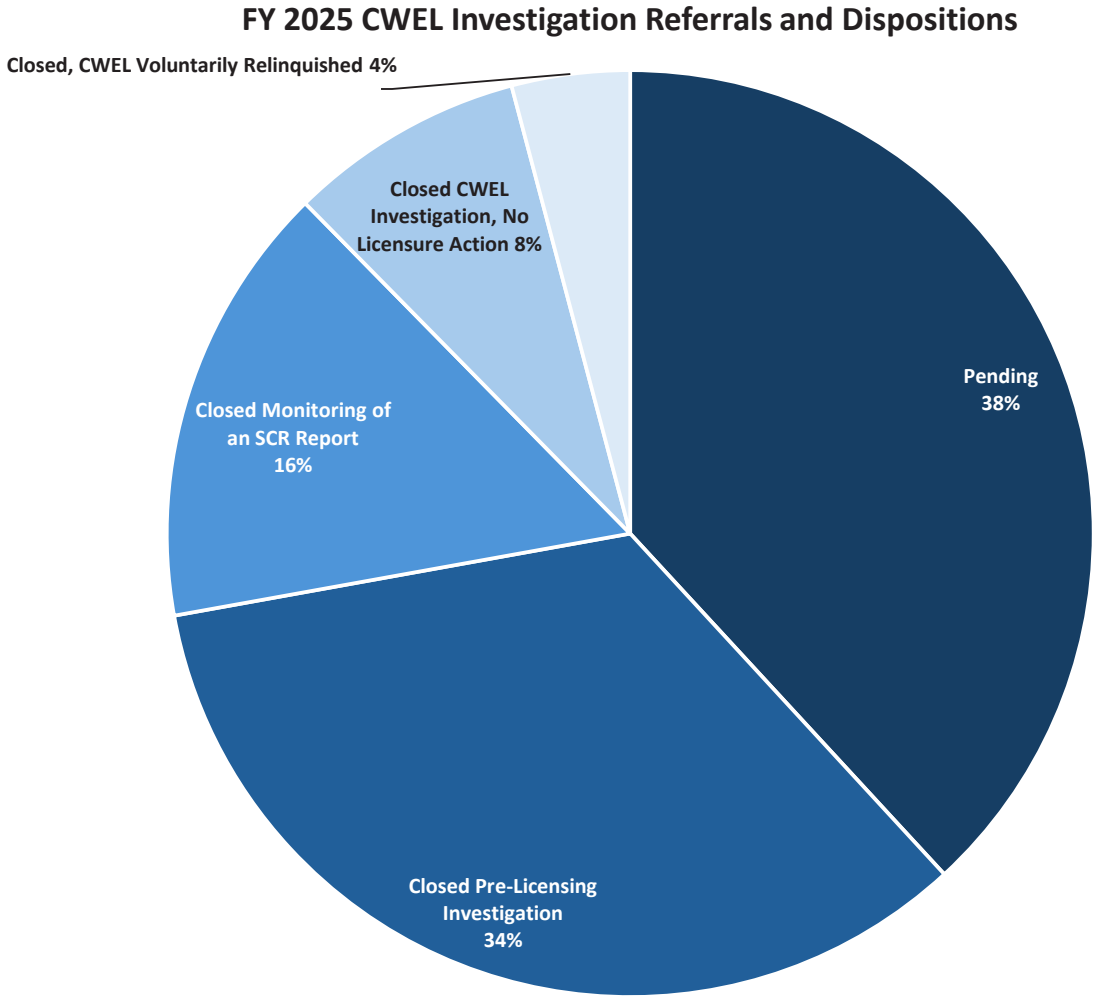
When a CWEL investigation is completed, the OIG determines whether the findings of the investigation support possible licensure action. Allegations that could support licensure action include a criminal conviction of any offense stipulated under the Criminal Code of 2012 and listed in section 4.2 of the Child Care Act; making any material misrepresentation relevant to obtaining a CWEL; an egregious act that demonstrates incompetence, unfitness or blatant disregard for one's duties in providing direct child welfare services; a pattern of deviation from standard child welfare practice; failing to provide information or documents regarding a licensure investigation; falsification of case records, court reports or court testimony; failing to report an instance of suspected child abuse or neglect as required by ANCRA; or being named as a perpetrator in a report indicated by DCFS. When licensure action is appropriate, the licensee is provided an opportunity for a hearing. An administrative law judge presides over the hearing and reports findings and recommendations to the CWEL Board. The CWEL Board then has the authority to make the final administrative decision regarding the suspension or revocation of a license.

Department Rule 412.40 provides that a licensee may voluntarily relinquish his or her license at any time during a pending licensure or disciplinary investigation, administrative proceeding, or subsequent court action. Department Rule 412.100 allows a former licensee to request the reinstatement of his or

her revoked, suspended, or relinquished license no earlier than 30 business days after receipt of the written notice of license revocation, suspension, or relinquishment. The OIG is notified within 10 days after receipt of a request for reinstatement of a license and may file a written objection to the request within 30 days after receipt of the notice.

In FY 2025, the ELRT referred 97 CWEL Complaints to the OIG for investigation and/or monitoring of an alleged Rule 412.50 violation. This is a 69% increase from FY 2024 CWEL Complaints.

FY 2025 CWEL Investigation Referrals and Dispositions	
Pending	37
Closed Pre-Licensing Investigation	33
Closed Monitoring of an SCR Report	15
Closed CWEL Investigation, No Licensure Action	8
Closed, CWEL Voluntarily Relinquished	4
FY 2025 CWEL Investigation Referrals Received	**97**



OIG Prosecution of FY 2025 CWEL Referrals

In FY 2025, the ELRT referred 97 CWEL Complaints to the OIG for investigation and/or monitoring of an alleged Rule 412.50 violation. Of the 97 CWEL complaints referred to the OIG, 32 complaints were simultaneously referred to the CWEL Board for preliminary suspension pursuant to Rule 412.90. Of the 32 preliminary suspensions imposed by the Board, 11 licensees requested a post-preliminary suspension hearing that was prosecuted by an IG attorney.

Licensure Action of FY 2025 CWEL Referrals

The following cases represent action taken against Child Welfare Employee Licenses (CWEL) in FY 2025.

License Relinquishments (4)

Three licensees relinquished their CWEL while licensure action was pending based on OEIG investigations which found that the licensee provided false information on a Federal Paycheck Protection Program (PPP) loan application. In an additional case, a licensee relinquished their CWEL during a pending OIG investigation of falsified case notes documenting in person home visits that clients reported did not occur.

Pending CWEL Board Final Decision (2)

The Office of the Inspector General issued charges as to two licensees based on failure to respond to a written request by the OIG. Both Licensees failed to appear at their scheduled pre-hearing and the ALJ sent Recommendations to Revoke based on Abandonment. The matters are pending final administrative decision by the CWEL Board.

FY 2025 Disposition of CWEL Referrals Pending from Prior Fiscal Years

There were 28 additional CWEL referrals opened in prior fiscal years that were pending at the beginning of FY 2025. Of these 28 cases, 22 were closed in FY 2025 and 6 remain pending.

FY 2025 Disposition and Status of CWEL Referrals Opened in Prior Fiscal Years	
Pending	6
Closed Monitoring of an SCR Report	6
Closed, CWEL Voluntarily Relinquished	5
Closed CWEL Investigation, No Licensure Action	4
Closed, CWEL Revoked	3
Closed, Reinstatement Request Denied	3
Closed Pre-Licensing Investigation	1
Total	**28**

CRIMINAL BACKGROUND INVESTIGATIONS

The Office of the Inspector General performs out-of-state Law Enforcement Agency Data System (LEADS) checks, a vital function for the field, for the purpose of providing information for evaluating child safety in the care of individuals. The Department is required by statute to assess the relevant criminal history of caretakers prior to the placement of children (20 ILCS 505/5(v)). Because the OIG meets the definition of a criminal justice agency in the Department of Justice Regulations on Criminal Justice Information Systems (Title 28, Code of Federal Regulations, Part 20, Subpart A) the OIG, unlike the Department, has access to criminal history outside of Illinois, through the Interstate Identification Index, within limits set by the National Crime Prevention and Privacy Act. LEADS, as dictated by state and federal law, cannot be used to conduct background checks for employment or licensing purposes. The Illinois Administrative Code forbids use of the LEADS network and LEADS data for personal purposes. OIG LEADS operators provide technical assistance to the Department and Child Welfare Contributing Agencies (CWCA) by preparing and providing reports from the checks of out of state criminal history for the purpose of child safety in emergency placement. Each case may involve multiple law enforcement database searches and may involve requests on multiple persons. A single inquiry may yield results from multiple states requiring evaluation of the response from each state or federal agency. LEADS operators must interpret the results and prepare a report to share. Though LEADS results may be used immediately, fingerprint checks are required for confirmation.

In addition to child protection investigator and caseworker requests, when the Placement Clearance Desk is considering a non-licensed home for placement and the Illinois LEADS contains an arrest which may pose a safety threat to a child, but there is no disposition information, OIG provides technical assistance in obtaining dispositions and needed information. The Placement Clearance Desk may also request an out-of-state LEADS check for approving a home for immediate placement of children. The OIG also provides information to the Director's Office when needed for evaluation of a waiver request.

In a continuing effort to provide information efficiently to child protection investigators and caseworkers, OIG has worked to utilize technology, as allowed within Illinois State Police regulations, to provide needed information more readily to the field. Through encrypted email channels OIG has created specific mailboxes for background checks from both the field and Placement Clearance Desk.

In FY 2025, OIG had seven LEADS operators: two primary operators and five secondary operators. During FY 2025, OIG LEADS operators conducted 8,065 queries, an increase of more than 200 from the prior year.

Law Enforcement Liaison

The Inspector General serves as the primary Department liaison to the Illinois State Police. If, during an investigation, evidence indicates that a criminal act may have been committed, the Office of the Inspector General (OIG) may notify the Illinois State Police. The OIG may also investigate the alleged act for administrative action only.

The OIG assists law enforcement agencies with investigations if requested, including gathering necessary documents. If law enforcement elects to pursue a criminal investigation and requests that the administrative investigation be put on hold, OIG will retain the case on monitor status. If law enforcement declines to prosecute, OIG will determine whether further investigation or administrative action is appropriate.

In FY 2025, the OIG made five referrals to the Illinois State Police for investigation of possible criminal activity by a DCFS employee. These cases involved theft of state funds, one by fraud and four cases with

hiding dual employment. All five cases were accepted for investigation and are pending. The State's Attorney in one county has requested assistance from the OIG in preparing prosecution.

In one case a federal enforcement agency requested investigative assistance from the OIG.

The OIG has continued to follow cases in which the OIG worked with law enforcement that resulted in criminal cases. In an FY 2023 investigation, in cooperation with the FBI and the Illinois state police, federal charges were filed on 16 defendants.

In an FY 2024 case the OIG's coordination with the Illinois State Police and the local State's Attorney's Office resulted in an employee's conditional discharge. In FY 2025 the OIG continued to provide information to the State's Attorney documenting violations of the defendant's conditional discharge which has now resulted in a criminal conviction. The OIG monitors cases which were referred by the OIG to law enforcement and may assist in the criminal investigation. In an FY 23 investigation, in cooperation with the FBI and the Illinois state police, federal charges were filed on 16 defendants for participating in a scheme to fraudulently obtain state funds designated for childcare services. At present, 16 defendants, including a former DCFS worker, have entered guilty pleas; 14 have been sentenced and two are awaiting sentencing. In December 2025, the former DCFS worker involved in the case was fined $4.1 million and sentenced to incarceration for 5 years, 10 months followed by 3 years of supervision.

In another case referred to law enforcement in FY 2024, a former worker pleaded guilty to two counts of theft and was sentenced to 24 months of probation and ordered to pay restitution.

INVESTIGATIONS

This Annual Report covers the time period from July 1, 2024 to June 30, 2025 (FY 2025). The Investigations section is three parts. Part I includes summaries of full child death and serious injury investigations submitted to the Director of DCFS. Part II contains aggregate data and case information for 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, Office of the Inspector General recommendations and the Department response. In the "Recommendations" section of each case, Office of the Inspector General Recommendations are in bold and the Department's responses to the recommendations follow.

PART I: DEATH AND SERIOUS INJURY INVESTIGATIONS

Death and Serious Injury Investigation 1

DEATH Nine months after entering care, the nearly 2-year-old youth in care sustained severe injuries that led to the toddler's death. According to the autopsy, the cause of death was blunt force trauma to the abdomen, and the manner of death was homicide. Earlier that day, the grandmother, who was the foster parent to the 2-year-old, brought the toddler over to the home of the toddler's mother while the grandmother went to work. The mother did not have unsupervised visitation with the toddler and the toddler was not authorized to be in her home. Later that same day, the maternal aunt, who lived with the mother and the toddler's 8-year-old sibling, reported leaving the toddler in the care of her paramour and returning to find the nearly 2-year-old unresponsive. Emergency services responded to the home and transported the child to the hospital where the toddler was pronounced deceased. The nearly 2-year-old's injuries at the time of death included blunt force trauma and visible injuries to the abdomen. No criminal charges have been filed for the death.

INVESTIGATION At the time of the death, the nearly 2-year-old was a youth in care placed with the maternal grandmother, who left the toddler with the maternal aunt, an unapproved caregiver. In the year prior to the toddler's death, the Department conducted a child abuse and neglect investigation, the toddler and the 8-year-old sibling entered foster care, and the court later returned the sibling home.

In the year prior to the death, the toddler sustained complex skull fractures with brain bleeding. The evaluating physicians, including a board-certified child abuse pediatrician, noted that the mother and maternal aunt's explanation of a fall one month earlier did not explain the infant's injuries. The doctors reported the injuries as concerning and noted they likely occurred from non-accidental trauma. Information about the seriousness of the toddler's injuries was part of the child protection investigation of abuse and neglect as well as a medical stipulation of facts in the court record. The Department indicated both the mother and the maternal aunt, who provided care to the toddler prior to the injuries, for head injuries by neglect (#52).

IG investigators found that in both the child protection investigation and the subsequent placement case, the family maintained that the injuries were related to a pre-existing seizure disorder, not non-accidental

trauma. The CWCA placement worker appeared to believe the family's statements regarding the cause of the injuries rather than the medical experts, which impacted future case decisions. The CWCA placement supervisor did not recognize the case worker's flawed use of information and allowed case decisions to be made that did not account for the significance of the toddler's injury and vulnerability. Both the CWCA placement worker and supervisor reported to IG investigators having no training on physical child abuse, including skull fractures.

IG investigators determined that the CWCA staff failed to recognize the family's disbelief of the abusive nature of the injuries as an indicator of the ability of the relative caregiver, who was the grandmother, or mother, to protect from future abuse. The lack of a definitive perpetrator and an unexplained injury called for greater scrutiny of caregivers entrusted with protecting the toddler and sibling in out-of-home care. The grandmother in this case also reported she did not believe the abuse, a troubling indication given that the two caregivers around the time of injury were the mother and the maternal aunt, both of whom would continue to have contact with the children. CWCA staff failed to educate the grandmother about the injuries or assess for her ability to protect, given her belief.

Failing to believe the abusive nature of the toddler's injuries or the perpetrator being a family member went on to influence assessment and service provision to the mother. The clinical screener initially noted concern about the mother's role in the toddler's injuries and ability to protect the toddler and recommended both consideration of a parenting capacity assessment and further clinical assessment about the visitation given the severity of the injuries. The clinical screener used the information from records and interviews to determine a poor prognosis for reunification. However, IG investigators found that the CWCA placement worker did not agree with the prognosis based on her faulty beliefs and advocated for not only a changing of the prognosis but of diminishing the opinion of clinical professionals in documented emails with the public defender. The CWCA placement worker requested a prognosis change despite not attending a requested staffing by the clinical screener to discuss any concerns regarding the completed assessment. Ultimately, the clinical screener agreed to change the prognosis from poor to deferred with no new information. IG investigators noted that the facts of the injuries remained the same, there was no witnessed accident, the mother and the aunt did not have a plausible explanation, and the evaluating child abuse medical experts ruled out a medical cause and opined that the injuries were abusive. The change in prognosis was based solely on the request of the CWCA placement worker, who continued to demonstrate a lack of understanding of the injuries or the opinion of medical experts. The change in prognosis reinforced the inaccurate position that the toddler's injures were not abusive and compromised child safety.

Five months after the children entered care, the agency agreed to unsupervised visitation by the mother and the court returned the 8-year-old sibling home on an order of protection. At this point in the case, the family's continued denial of abuse and the CWCA placement worker's alignment with the family allowed for a failure to critically evaluate the information available.

RECOMMENDATIONS

1. The Office of the Inspector General will share the report with the involved Child Welfare Contributing Agency (CWCA).

The OIG shared the report with the involved CWCA. In response to the report, the CWCA implemented corrective actions which included enhanced training for staff, a comprehensive review of the CWCA's case management policies and procedures, and increased monitoring of case management practices.

2. The involved CWCA's management should consider appropriate disciplinary action as to the CWCA placement worker in accordance with the agency's personnel policy and practices. This report should be shared and reviewed with the CWCA placement worker as part of the action taken.

The CWCA reviewed the report with the CWCA placement worker to address the specific issues identified in the report and took appropriate disciplinary action.

3. The report should be shared with the Agency Performance Monitoring and Execution (APME) team assigned to the involved CWCA to inform their ongoing monitoring of the agency.

The report was shared with the assigned Agency Performance Monitoring and Execution (APME) team.

4. The report should be shared with the Director of the Integrated Assessment Program for internal discussion with Integrated Assessment staff, regarding parameters on changing the prognosis when requested by the field.

DCFS Clinical will work with the Integrated Assessment providers to develop a protocol for the parameters on changing the prognosis when requested by the field. Once a protocol is developed, it will be shared with all IA screeners through meetings, emails and supervision.

5. The report should be shared with the involved Clinical Screener and used as a teaching tool.

The report was shared with the Clinical Screener and used as a teaching tool.

6. The report will be used in the OIG's Error Reduction training regarding use of expert professional opinions in decision making.

The report will be used in the OIG's Error Reduction training.

Death and Serious Injury Investigation 2

DEATH An 8-year-old boy was brought to the hospital after he was found unresponsive, with a cord around his neck. Upon arrival at the hospital the boy had no brain activity and died five days later. The boy's death was ruled an accident after his siblings reported they were playing with an elastic cord when the child wrapped the cord around his neck. The Department investigated and unfounded the child's mother for death by neglect (#51). The Department also unfounded the mother and stepfather for head injuries by neglect (#52) to the child and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the child's 2-year-old, 4-year-old, and 5-year-old siblings. In the year prior to the child's death, the Department conducted a child protection investigation for abuse to the child's stepsister. The OIG investigation addressed deficiencies in the prior child protection investigation.

INVESTIGATION Four months before the child's death, the Department initiated an after-hours child protection investigation against the child's mother and stepfather for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the child's 13-year-old stepsister following a report that police responded to the home after the parents hit the stepsister. The stepsister later alleged her father (the child's stepfather) threatened to kill her while he pointed a gun at her, then he shot the gun into the wall. The stepsister was transported to the hospital for mental health concerns. An on-call Child Protection Specialist (CPS) initiated the investigation. The next morning, the primary CPS met with the stepsister at the hospital and took photos, including one photo of her face that showed possible discoloration on her forehead. The CPS did not document whether she observed a bruise or swelling on the stepsister's forehead. Following medical evaluation, the hospital discharged the stepsister. The stepsister's legal guardian was her maternal aunt, who had been her guardian for many years, and who lived in a neighboring state. The stepsister reported she had been visiting her father's family for a few weeks prior to the incident. The maternal aunt transported the stepsister to the Children's Advocacy Center for a forensic interview, then transported her back to her home in the neighboring state. The primary CPS submitted a safety assessment for the stepsister in which she was assessed safe because she returned to her maternal aunt's care.

During the forensic interview, which the primary CPS and police observed, the stepsister again described the incident. The 13-year-old stepsister stated her father sent the five younger children in the home to their rooms, retrieved a handgun from above the refrigerator, cocked the gun and pointed it at her, threatened her, and discharged the gun into the wall. The parents denied the allegations. Police did not recover a handgun, but did recover a bullet that was lodged in the wall. The father was later found guilty of reckless discharge of a firearm.

Two days later, the CPS documented a phone call with the police detective assigned to the case, who asked if DCFS information could be shared. There were no further efforts documented in the investigation for over two months. Two days before the closing supervisory note, the CPS documented a video call with the stepsister. The CPS documented that the stepsister had returned to Illinois and was living with her birth mother, and she conducted a closing safety assessment during the call with the stepsister and her birth mother. The CPS's cell phone records also confirm a call that same day with the stepsister's maternal aunt, though the call is not documented in SACWIS. There is no closing safety assessment entered for the case. Less than three weeks before the serious injury that led to the child's death, DCFS indicated the child's mother and stepfather for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the child's stepsister.

The child protection investigation was deficient in making required contacts, coordinating with other professionals, creating appropriate documentation, and providing adequate supervision. The CPS did not observe the home, meet with the parents, or meet with or assess the safety of the five younger children in the home, who were between the ages of 2 years and 9 years old at the time of the incident. In her interview with IG investigators, the CPS denied knowledge that there were other children in the home. The primary CPS only entered three contact notes: her initial in-person contact with the stepsister, a call with the police detective assigned to the case, and a video call with the stepsister at the closure of the investigation. The primary CPS's assigned supervisor did not enter any supervision notes during the investigation. The final supervision note was entered by a different supervisor who filled in when the primary supervisor was out of the office. The CPS obtained the police report, but did not document efforts to obtain medical records, child protection history from the neighboring state regarding the stepsister's family, or a request for a courtesy visit to the home in the neighboring state. IG investigators obtained an extensive history from the neighboring state of child protection investigations involving the stepsister's family, including a child protection investigation earlier that same year.

At the time the investigation was pending, the local field office to which the investigation was assigned was only 50% staffed. In addition, the primary CPS had only been a child protection investigator for approximately one year at the time the investigation was initiated, and the child protection supervisor who completed the final supervision had been a supervisor for less than three months.

RECOMMENDATIONS

1. The Child Protection Specialist should be disciplined for her failure to ensure required investigative tasks were completed in the child protection investigation.

The CPS was disciplined.

2. The CPS's assigned supervisor should be disciplined for not ensuring the CPS completed required investigative tasks in the child protection investigation.

The supervisor was disciplined.

3. The report should be shared with the supervisor who signed off on the investigation as a teaching tool.

The report was shared with the supervisor and used as a teaching tool.

4. The report will be used in the OIG's Error Reduction training.

The report will be used in the OIG's Error Reduction training.

Death and Serious Injury Investigation 3

DEATH A relative found the 13-year-old dead while vacationing out of state. The Department did not investigate the teen's death, and no criminal charges were filed. In the year prior to the teen's death, the Department conducted three child protection investigations for allegations of sexual abuse (#21), substantial risk of harm (#60), and environmental neglect (#82) and closed an intact family services case.

INVESTIGATION In the year prior to the teen's death, the family had an open intact case with a Child Welfare Contributing Agency (CWCA) to address domestic violence and parental substance abuse. The precipitating events included the father hitting the mother in front of the teen, and law enforcement finding drugs and paraphernalia in the car and the mother's purse. However, during the 20 months that the CWCA provided oversight of the case and monitoring of the family, IG investigators found that the mother never engaged in domestic violence services, the family never engaged in therapy, and there was no corroboration that the mother completed substance abuse treatment. The CWCA intact worker failed to obtain the results of any drug tests completed and relied on the mother's self-report despite a documented history of substance abuse. Relying on the mother's self-report failed to assess the risk or possibility of continued drug use posed to the teen. IG investigators found that the CWCA intact supervisor falsely believed that domestic violence records could not be obtained, thus preventing intact staff from monitoring the need for the service. Intact staff reportedly referred the teen to therapy services during the intact case, yet there was no documentation that the service ever occurred. Additionally, the teen appeared to receive support from school staff, but the CWCA intact staff never obtained any information from the school. Failure to use the school as a source of information impacted service provision to the teen. Corroboration of a parent or child's participation in services has the potential to impact decision-making about client cooperation, progress in services, and risk to children. A main tenet of intact family services is to provide services that mitigate the risk of further maltreatment to the children. IG investigators determined that CWCA intact staff did not obtain any information from providers about services or follow up with additional referrals when the mother failed to follow through. Failure to obtain information from community providers not only violates DCFS Procedures, it also significantly impacts an assessment of a family's progress in services and child safety.

At several points in the intact family services case, situations occurred that required further assessment of the family and the risk to the teen. The mother never obtained an order of protection against the father, despite the significant history of domestic violence, including a previous order of protection she obtained. The CWCA intact supervisor told IG investigators that the only recourse for the agency was to continue to encourage the mother to follow through. Intact staff did not consider the mother's inaction as an indicator that she may not be able to protect the teen. Rather, intact staff regularly documented throughout the case that the mother could protect solely on statements that the family would not allow the father in the home. Additionally, CWCA staff never obtained police records regarding the family despite multiple instances throughout the case that involved known police response to the home. IG investigators obtained police records which documented seven responses to the home during the intact case specifically for domestic violence. Failure to obtain independent information about families with domestic violence histories severely limits the ability to assess the parent's capacity to minimize risk to the child and protect from future harm.

Ten months into the intact case, the Department indicated the father for sexual abuse (#21) to the teen after the teen disclosed the father's sexual abuse as well as a pattern of the family allowing the father to live in the home. The CWCA intact staff never obtained police reports or documents that led to the father's arrest for the sexual abuse. The father had not participated in services during the intact case and reported that the teen lied about the sexual abuse. CWCA intact staff did not consider the

mother and grandmother allowing the father to live in the home as a failure to protect the teen. IG investigators found that CWCA intact staff appeared anchored to their initial assessment of the mother and grandmother's ability to protect the teen despite new information that the father stayed in the home and slept in the same room as the teen.

After the intact case had been open for a year, the mother required hospitalization; she was later placed on life support. The family reported the teen had gone to live with a relative. The CWCA intact supervisor told IG investigators they relied on the family for information about the mother's medical condition and prognosis. However, there were no documented efforts in the case file to see the mother in the hospital and gain her consent to discuss her treatment and prognosis.

After the mother's hospitalization, the CWCA referred the teen and the relative to the Extended Family Support Program (EFSP) to assist the relative with obtaining guardianship through probate court. The CWCA intact supervisor told IG investigators they did not consider pursuing dependency. The decision to move forward with EFSP did not consider the complicated nature of the family, with one parent on life support, unable to consent, and one parent an indicated perpetrator of sexual abuse.

The teen had a significant trauma history and would have benefited from services to address the history in addition to the father's sexual abuse and the mother's medical illness. When intact staff determined the relative could meet the teen's needs, the assessment was made with insufficient information, and intact staff failed throughout the entirety of the case to adequately assess the teen's needs. The referral form completed by the CWCA intact worker did not include information about the mother's prognosis, the father's pending criminal charges or the teen's significant trauma history. The current referral form for Extended Family Support Program (ESFP) does not provide information regarding the child's functioning, school performance, or trauma history. At the time of referral to EFSP, the teen had a history of witnessing domestic violence, parental substance abuse, sexual abuse by her father, and the pending death of her mother. Omitting such salient information to an agency charged with shepherding a caregiver in transfer of guardianship allows for a disconnect in services and wellbeing for the child.

The CWCA intact worker closed the family case one week after completing the referral to EFSP without meeting with EFSP staff. Transitional meetings are crucial when transferring a family from one provider to the next and provide an important opportunity for information sharing. Requiring staffing discussions between intact and EFSP as well as keeping an intact case open could allow for effective coordination of services between the Intact and EFSP workers.

RECOMMENDATIONS

1. The CWCA intact worker resigned from the CWCA and was hired as a child protection investigator with the Department. The Department should share a redacted copy of the report with the CPS and their current supervisor for training purposes.

The report was shared and discussed with the CPS and current supervisor.

2. The Inspector General will share a redacted report with the CWCA. The CWCA should review the report with the intact supervisor and take appropriate action.

The Inspector General shared a redacted copy of the report and met with the CWCA to discuss the findings of the report. In response to the report, the CWCA provided training to all CWCA staff and increased oversight to address the deficiencies found in the report. The CWCA also reviewed the report with the intact supervisor and provided additional training.

3. Procedures 302.389, Extended Family Support Program (EFSP) should be amended to include that during Intact Family Services Cases, when a relative caregiver is referred to the Extended Family Support Program, the intact worker and extended family support provider should conduct a staffing with the caregiver to ensure continuity of services. The staffing should include a plan to ensure that current services for the child(ren) are not disrupted as well as a discussion of historical information

that the caregiver and extended family support provider should be made aware of to support the child(ren).

The referring worker and the EFSP worker meet after the referral is completed to coordinate care. This is currently in the program plan and in a draft of procedures which will be completed in 2025. This care coordination meeting can be virtual, by phone, or in person. The EFSP Program Administrator and team will develop a form on which EFSP workers will document that a referral was accepted, the services the client is interested in, and any concerns with obtaining the parent's cooperation in the caregiver obtaining guardianship. This could be utilized for all referral sources (SCR/hotline sends 66% of referral, DCP sends 25%, and Intact sends <10%). The current EFSP referral process allows space for the worker to document historical information that the caregiver and extended family support provider should be made aware of to support the child(ren). An updated EFSP referral form is in development and will also include space for the referring workers to include historical information that the caregiver and EFSP provider should be aware of to support the children.

4. The CFS 1448, Extended Family Support Program Division of Child Protection Referral Form, should be amended to include a section detailing current and/or recommended services that are either being provided or are needed to support the child(ren) (i.e. counseling, school enrollment, Medicaid, etc.).

If the parent provides authorization to release the child's records to the EFSP provider, then the referring worker can provide a copy of the child's service plan (if completed), which would detail current and/or recommended services that are being provided or needed to support the children. Over 90% of referrals come from SCR/hotline and DCP, who do not complete service plans. In that case, the referring worker can still document recommended services on the EFSP Referral Form. If the child's legal guardian signs a release of information, the referring worker can also document current services. The CFS 1448 is under revision and will incorporate space to document this information when appropriate. The EFSP Program Administrator and team are continuing the work on the updated procedures and the new form, and both should be completed and released in 2026.

5. The Department should consider amending Procedure 302.389, Extended Family Support Program to require that an Intact Family Services Case remain open for 60 days to allow for coordination between the intact worker and extended family support provider to ensure full support of the child(ren) and family.

Intact Family Services is a voluntary service, therefore DCFS cannot require a family to keep their case open for any length of time. However, DCFS can allow the case to remain open for up to 60 days after referral to EFSP from Intact, unless a parent declines ongoing intact services or the court orders case closure. Procedure 302.388 language is under revision to include the above language.

6. The report will be shared with the Inspector General's Error Reduction Training staff.

The report will be used in the OIG's Error Reduction training.

Death and Serious Injury Investigation 4

ISSUE Beginning in FY 2022, through the preliminary review of complaints received through notification of child deaths and the general intake process, the OIG identified child protection investigations in which numerous extensions were granted, allowing investigations to remain open for significant periods of time past the statutorily mandated 60-day investigative timeframe (325 ILCS 5/7.12, Rule 300.90, and Procedure 300.50(j)). According to statute, the Department may extend this investigative period for good cause shown (325 ILCS 5/7.12). In reviewing these cases, the OIG identified 15 child protection investigations each with more than 6 approved extensions.

INVESTIGATION The OIG reviewed 15 child protection investigations with more than 6 approved extensions, with minimal investigative work documented during those extensions.

DCFS is statutorily mandated to complete child protection investigations and make final determinations within 60 days. However, 30-day extensions can be granted for good cause. (325 ILCS 5/7.12) The Department has discretion in determining whether good cause exists for an extension, and this discretion is guided by established rules and procedures. While extensions may be necessary in some cases, extensions should be granted judiciously, in compliance with the statutory mandate of good cause shown, and with careful consideration of the potential consequences for the families being served and the integrity of the investigative process.

The Department's focus during all child abuse and neglect investigations is the safety of the child victims. There are times when a child protection investigation cannot be completed within the 60-day timeframe and more time is needed to gather crucial evidence, requiring the child protection specialist to request an extension. In addition, if law enforcement or other agencies are involved, delays in their investigation can impact the overall timeline, necessitating an extension. In some cases, staffing shortages or a high volume of cases can also contribute to delays.

After the initial 60-days of a child protection investigation, the investigation status moves from "pending" to "undetermined", allowing child protection investigators and supervisors to clearly see which child protection investigations are in extension periods. Child protection supervisors must ensure that work is being completed on these outstanding investigations and create a case plan for completing the investigation within the extension period. The Department already requires a heightened level of scrutiny on these investigations by requiring an Area Administrator to review and approve each extension. However, through the OIG's review of these 15 child protection investigations, Area Administrators rarely document communication with the child protection supervisor or child protection specialist on creating a plan to complete the investigation or follow up on why tasks cannot be completed within the extension period.

The OIG found that reasoning for extensions granted provided insufficient information for a good cause extension, in violation of the statutory requirement and Department Procedures. After the extensions are approved, in most instances, there is no documented plan for completing the outstanding tasks. The data gathered through this review shows that most contact occurs prior to the first extension and after the final extension granted. The average length of time these 15 child protection investigations reviewed were open was 335 days.

In the child protection investigations reviewed, multiple extensions were granted even though the investigator completed little to no work during the previous extension period. According to Department Procedure, the child protection specialist (CPS) requesting the extension must "list the reasons the investigation cannot be completed within 55 days, activities to be completed, who is responsible for completing each activity and the expected date of completion." (DCFS Procedure 300.50(j)(2)). Of the extensions reviewed, none of the reasons for extension requests provided all necessary information. In 46% of the reviewed extensions, a reason for extensions used generic terms such as "investigative tasks" or "additional tasks" without specificity.

In 73% of the extensions reviewed, there were no contact notes between extensions, in violation of Department procedure which requires, "There must be information and activities contained within contact and supervisory notes documenting the progress of the investigation and plans for completion." (DCFS Procedure 300.50(j)(2)). It is important for workers to document any efforts on the case between extensions and provide a reason why they were unable to complete the investigation.

As the Department strives to lower caseloads and address staffing shortages, child protection management should address the issue of extensions granted without good cause. Area Administrators should follow Procedures to ensure that child protection specialists and supervisors are working diligently during

these extension periods. If further extensions are needed, for good cause, they should be documented as per Department Procedures.

RECOMMENDATIONS **1. The Department should conduct a review of all undetermined cases pending for more than 6 months to determine if additional extensions are warranted and facilitate closure as soon as possible.**

The Department has implemented measures that monitor all undetermined reports on a weekly basis. Child Protection is doing a weekly Undetermined Status Update for all undetermined reports. In addition, the Department has greatly reduced the number of undetermined cases through additional hiring and aggressive follow up. Child Protection holds a weekly Undetermined Status Update for all undetermined reports.

2. A redacted copy of the report should be shared with Child Protection Regional Administrators. The Regional Administrators should use the redacted report to provide training and education to Area Administrators on the appropriate use of extensions.

The Department shared a copy of the report with Child Protection Regional Administrators. The Regional Administrators will use the report to provide training and education to Area Administrators on the appropriate use of extensions.

3. The Department should require Child Protection Regional Administrators to conduct quarterly reviews of child protection investigations pending for more than 6 months to ensure timely completion of investigations.

The Department has implemented measures that monitor all undetermined reports on a weekly basis. Child Protection is doing a weekly Undetermined Status Update for all undetermined reports. In addition, the Department has greatly reduced the number of undetermined cases through additional hiring and aggressive follow up. Child Protection holds a weekly Undetermined Status Update for all undetermined reports.

Death and Serious Injury Investigation 5

ISSUE In reviewing FY 2023 and FY 2024 child deaths that met OIG criteria for review, the OIG identified a subset of cases of medically complex children for whom the Department did not appear to fulfill its mission of promoting the safety and wellbeing of children, youth and families. The OIG review focused on a systemic assessment through an analysis of records rather than highlighting individual case concerns, for the purpose of identifying areas in which the Department, specifically through its nursing services, can better ensure the safety of and provide services to these children and families that become DCFS involved. IG investigators found, in the review of deaths of medically complex children, that errors involving identification of the medical complexities, communication between child welfare and community partners and use of the DCFS Nurses impacted investigations and subsequent case management of this vulnerable population.

INVESTIGATION From FY 2023 and 2024, the OIG specifically identified 83 deaths of medically complex children who had DCFS involvement in the 12 months prior to their death. IG investigators used multiple criteria to determine eligibility of a child death for inclusion in the sample. The child must have been medically complex pursuant to the criteria for medical complexity listed in DCFS Procedures 302 Appendix O. The child must have been reported as deceased between FY 2023 and 2024. Lastly, the child must have been involved with DCFS in the year prior to their death. DCFS involvement included Division of Child Protection (DCP) investigations, Intact Family Services, Youth in Care (YIC), and Child Welfare Service Referrals.

During child protection investigations, the first point of contact with DCFS for many of the families, approximately half of the sample's investigators did not complete a DCFS Nurse referral, despite the requirement in procedures. This first step in identifying these children and their needs is crucial to ensuring that decisions about child safety and final findings are informed by their medical care requirements. As DCFS transitions to the SAFE Model, training of both hotline operators and child welfare staff conducting investigations should highlight the need to ensure identification of special needs at the outset of DCFS involvement. Ensuring early identification of the special needs of these children allows for timely referral to consultation services through the DCFS Nurse.

Effective communication and collaboration are main tenets of best practice in all aspects of child welfare. However, the IG review of DCFS involvement of the 83 children and families found issues with both communication and collaboration during investigations, intact family cases and youth in care cases. Information from medical records was not always available or utilized by involved child welfare staff, who cited issues with obtaining and accessing medical records. Delays in requesting information, especially during child protection investigations impacted the ability to inform decisions made. Records requested at the end of investigations rarely informed the investigation and did not consistently transfer to follow up services in intact families or youth in care, thus creating a silo of medical information. DCFS and CWCA staff had limited direct contact with medical providers and instead relied on caregivers to relay information including monitoring of needed appointments. Relying on self-report regarding a child's medical care creates a missed opportunity for assessment and allows for errors in transmission of information. Parents or caregivers may not disclose all information or may filter information they deem unnecessary, especially if it is critical of the parents' ability to care and follow up with the child's medical care. Further, this also translated into child welfare staff not routinely contacting medical providers, including in-home nursing staff or adjunct specialty care for information for or participation in Child and Family Team meetings. Failure to include the medical team to discuss a child and family's case are missed opportunities to model communication and collaboration between the family and medical providers who will likely continue to care for the child when DCFS is no longer involved in the family's life. Solidifying connections between community partners and families increases the possibility for better outcomes, especially considering issues that may have initiated child welfare involvement, such as failure to keep appointments, give medications or use of treatment modalities. Involvement of relevant providers allows for a true partnership when caring for these children that may, at times, require intense and collaborative care.

The current model for using DCFS Nurses is a point in time consultation at the time of a referral. That approach may not be sufficient for children with medical complexities. Instead, DCFS Nurses can be a critical resource for investigators and case workers throughout the life of a case. Nursing expertise can better inform field staff about a child's medical diagnoses, medications, treatments and management of life sustaining care. Such knowledge is likely beyond the general scope of child welfare staff who have little evidence-based training in caring for medically complex children. Using nursing expertise in early assessment of parenting and in case planning can ensure that there is an informed approach to service intervention. Targeted nursing intervention with children and families allows for a more individual approach to meet the varied needs of these children. Additionally, DCFS Nurses likely are better informed to assist in removing barriers to obtaining medically needed resources such as in home nursing, specialized equipment and transportation of medical equipment dependent children. As DCFS continues to implement the SAFE Model, consideration of tailoring the DCFS Nurse role to the framework would help assist direct field staff in both investigations and case management. Use of DCFS Nurse expertise in assessing parental or caregiver understanding of the medical needs of the child will better identify areas for training, development and support. Additionally, use of DCFS Nurses in client service planning will ensure that interventions target the identified needs for parents and caregivers. Creating a team approach with consistent input from a nursing professional enhances the interventions and may strengthen outcomes for children and families.

RECOMMENDATIONS **1. The Department should share the report with the DCFS Medical Director and the Chief of Nursing Services to facilitate a review and discussion of issues raised in this report involving assessment and service provision for medically complex children. The DCFS Medical Director and Chief of Nursing Services should collaborate with Department Administrators responsible for the SAFE Model in developing a framework for the role of DCFS nurses.**

The report has been shared with the DCFS Medical Director to facilitate collaboration with Department Administrators responsible for the SAFE Model to implement the recommendation.

2. The Department should share a redacted copy of the report with SAFE Model training facilitators and DCFS Administrators responsible for the SAFE Model implementation to inform the role of DCFS nurses in the new SAFE model.

The Department will share a redacted copy of the report with the SAFE Model training facilitators and DCFS Administrators responsible for the SAFE Model implementation.

3. The Department should incorporate DCFS Nurses in the SAFE Model structure, including involvement in the family assessment; protective capacity of parent determinations; and the development of case planning involving medically complex children.

The Department will share a redacted copy of the report with the SAFE Model training facilitators and DCFS Administrators responsible for the SAFE Model implementation to address the recommendation.

4. The OIG reiterates a prior OIG recommendation that the Department should explore the feasibility of electronic storage of attachments to child protection investigations, such as medical records obtained during the investigation, in the Department's new child welfare data system, IllinoisConnect.

IllinoisConnect will support the storage of all media types (documents, photos, video, and audio). Implementation within IllinoisConnect will occur in 2026.

5. The report will be used in the Office of the Inspector General's Error Reduction training.

The report will be used in the OIG's Error Reduction training.

PART II: CHILD DEATH REPORT

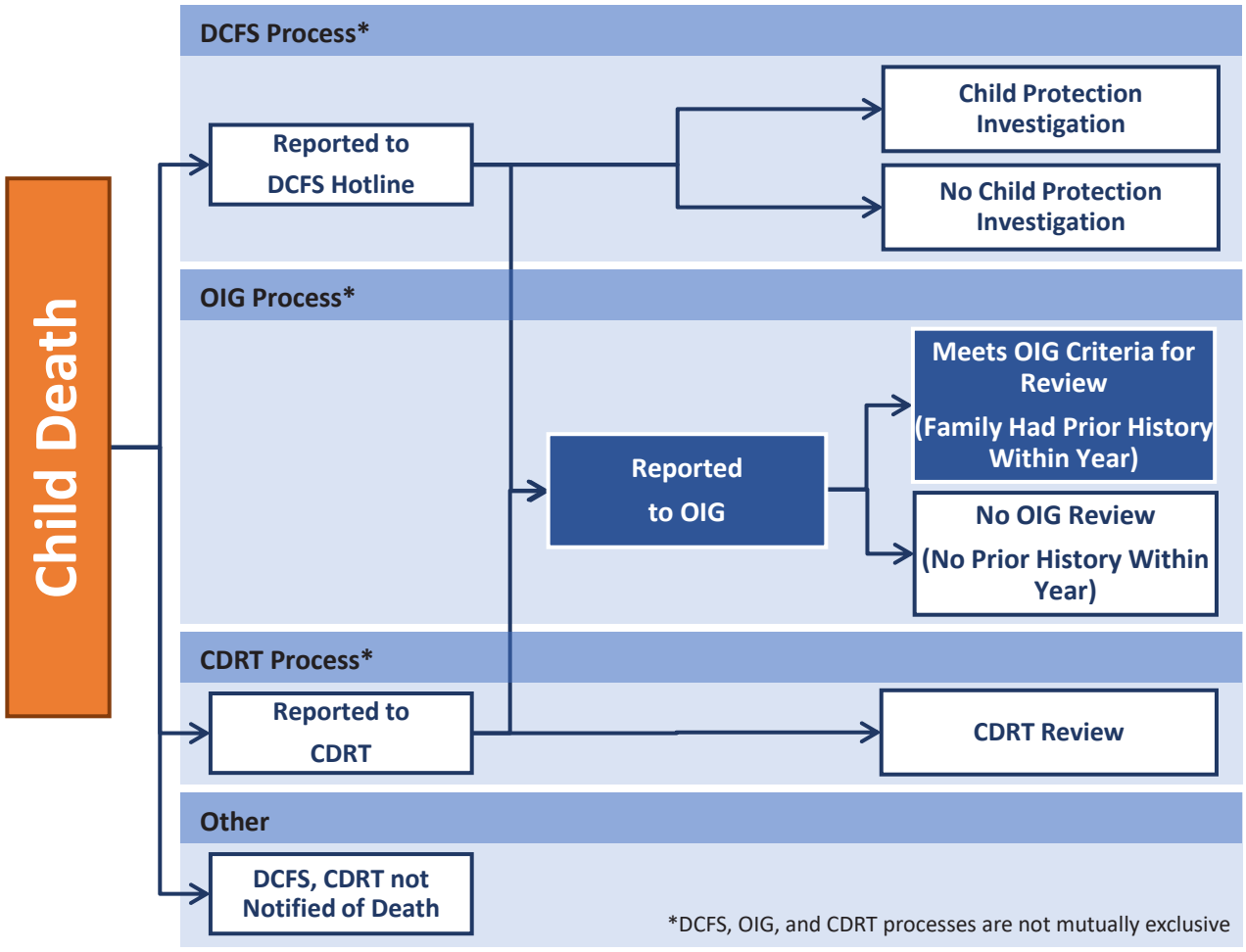
The Inspector General investigates deaths of Illinois children whose families have been involved with the Department of Children and Family Services (DCFS or Department) within the preceding 12 months (89 Ill. Adm. Code 430.30).

The Office of the Inspector General staff receive notification of the death of a child from the Illinois State Central Register (SCR), the Child Death Review Team (CDRT), or other public sources.

If a child death meets IG criteria, IG staff initiates an investigatory review of records. IG investigators review the death reports and information available through the Department's computerized records, DCFS and CWCA case records, and additional records as needed.

The OIG conducts full investigations when malfeasance or misfeasance of Department and CWCA employees or systemic issues are identified in the Department's or CWCA's prior involvement with the family. As part of a full investigation, IG staff may request additional records – often including social service, medical, police, and school records – and may conduct interviews. A full investigation may result in a report to the Director of DCFS.

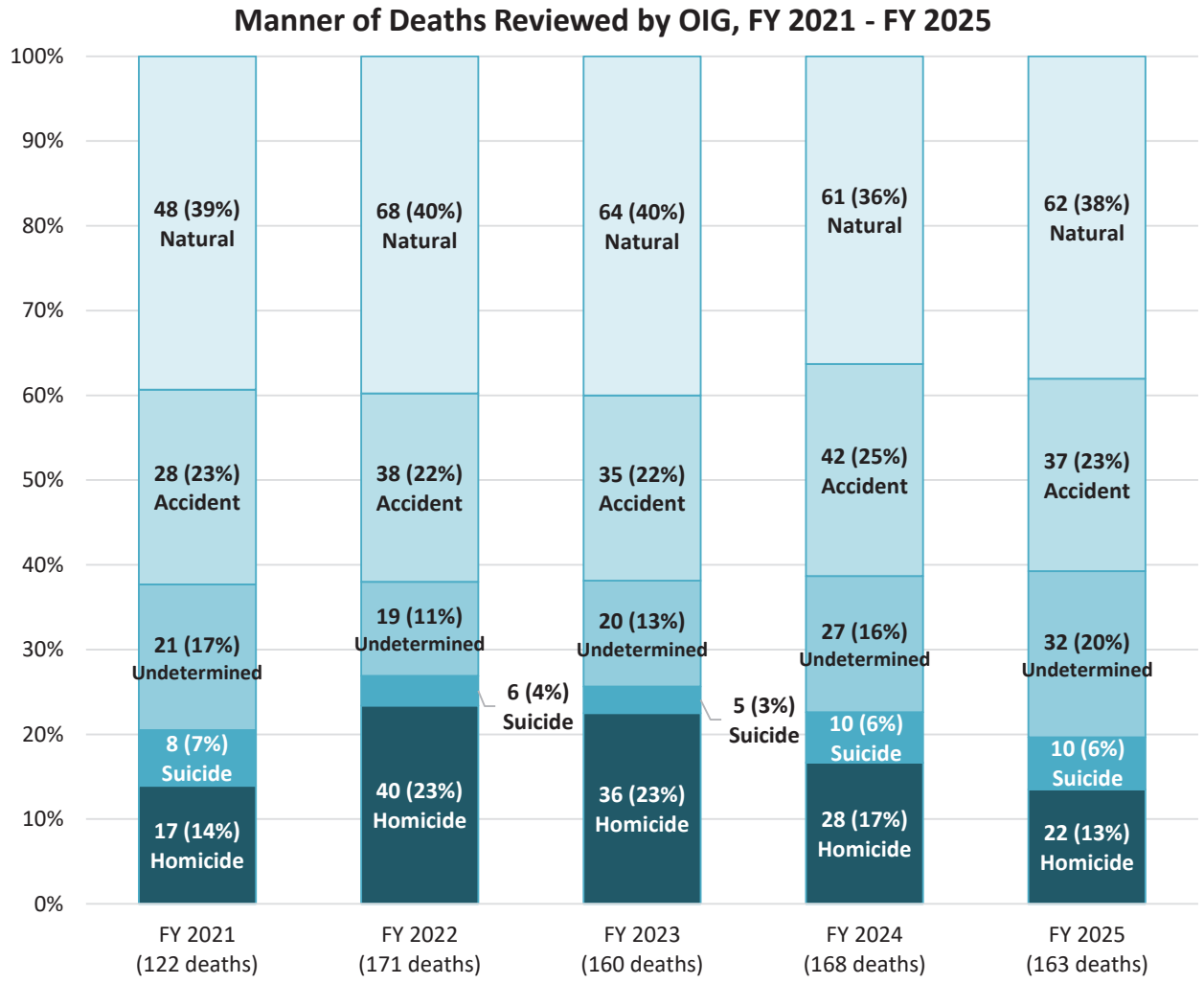
The OIG received 611 notifications of child deaths between July 1, 2024 and June 30, 2025 from a variety of sources including SCR, CDRT, the media, and the medical examiner's database. Some children's deaths were reported more than once through multiple sources. A total of 540 children were reported deceased during Fiscal Year 2025. Of those 540 reported deaths, 163 child deaths met OIG criteria for review. A summary of the family's DCFS involvement within the year prior to each child's death is included in this



Annual Report. IG investigators determined 13 deaths in FY 2025 required full investigations, and five deaths will be reviewed in a pending systemic issue report. Comprehensive summaries of the five death investigation reports submitted to the Director in FY 2025, which may include deaths that occurred in earlier fiscal years, are included in Part I: Death and Serious Injuries Investigations.

STATISTICAL SUMMARY

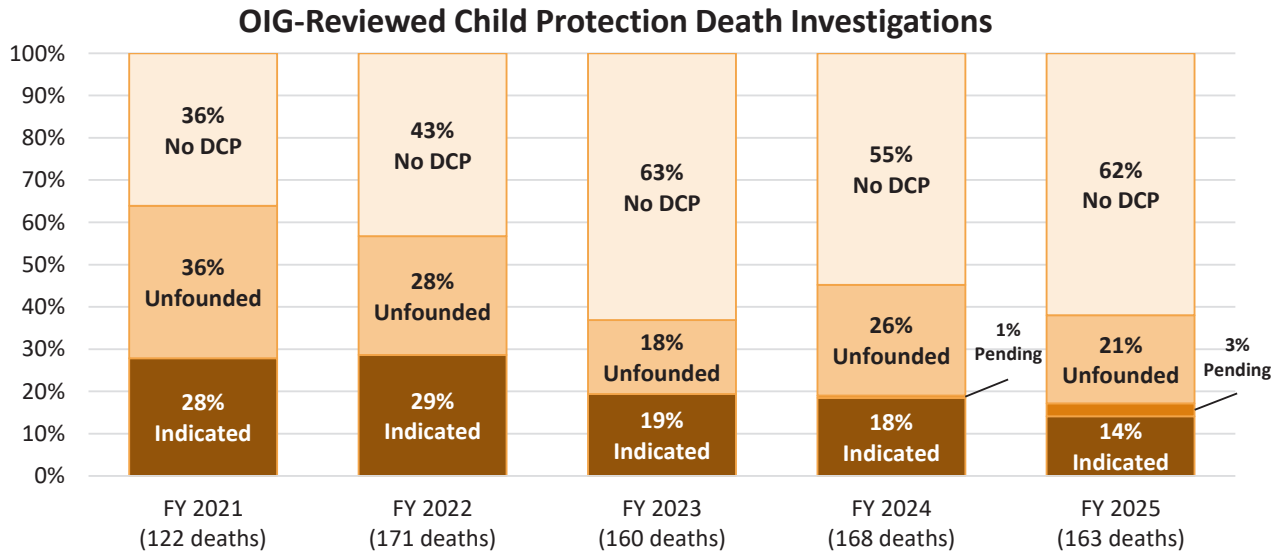
The following is a statistical summary of the 163 child deaths reviewed by the OIG in FY 2025. The first part of the summary presents child deaths by age and manner of death, case status and manner of death, county and manner of death, and child protection death investigations by result and manner. The second part presents a summary of deaths classified in five manners, as determined by coroners, medical examiners, or pronouncing physicians: homicide, suicide, undetermined, accident, and natural. This year there are eight deaths for which autopsy results have not yet been released and thus this report has a list of deaths classified under a pending manner of death section.



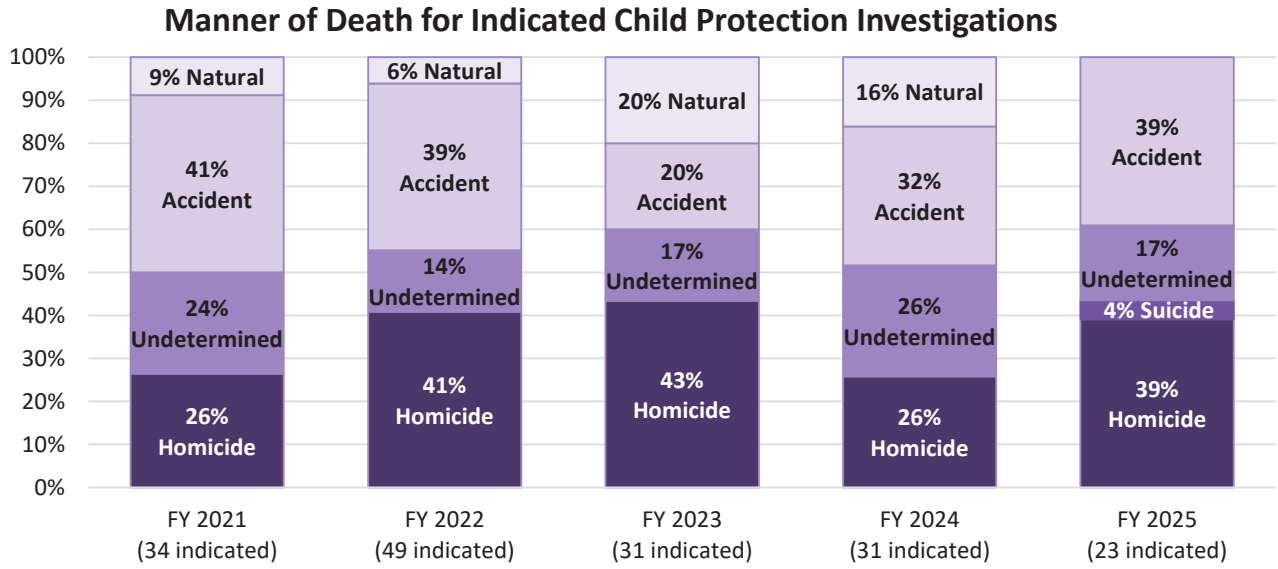
Child deaths with a pending manner of death are included above in the undetermined category.

Of the 163 child deaths reviewed by OIG in FY 2025, the Department conducted a child protection investigation for allegations of death by abuse or neglect in 62 (38%) of the deaths. Of the 62 deaths investigated by the Department, nine of the deaths were ruled homicide in manner, two were ruled suicides, fifteen had an undetermined manner, 18 had a manner of accident, and 14 had a manner of natural. Autopsy results have not been released for four of these deaths.

Of those 62 deaths investigated by the Department, the Department indicated a perpetrator for death by abuse or neglect in 23 deaths (37%). Of the investigations that were indicated, 8 (35%) were indicated for death by abuse (#1) and 15 (65%) were indicated for death by neglect (#51). The Department unfounded an alleged perpetrator for death by abuse or neglect in 34 child protection death investigations (55%); five child protection death investigations (8%) remain pending at the time of this report.



Of the 23 deaths in which the Department indicated a perpetrator for death by abuse or neglect, nine were ruled homicide in manner (39%), four had an undetermined manner (17%), nine were ruled accidental in manner (39%), and one had a manner of suicide (4%).



Child deaths with a pending manner of death are included above in the undetermined category.

Table 1: Child Deaths by Age and Manner of Death								
Child Age	**Homicide**	**Suicide**	**Undetermined**	**Pending**	**Accident**	**Natural**	**Total**	**Percent**
At birth	0	0	0	0	0	0	**0**	**0%**
0 to 3 months	2	0	16	2	7	14	**41**	**25%**
4 to 6 months	0	0	4	0	3	2	**9**	**6%**
7 to 11 months	1	0	1	3	1	2	**8**	**5%**
12 to 24 months	1	0	0	0	1	11	**13**	**8%**
2 years	0	0	0	1	1	3	**5**	**3%**
3 years	0	0	0	1	1	3	**5**	**3%**
4 years	1	0	1	0	3	3	**8**	**5%**
5 years	0	0	0	0	0	3	**3**	**2%**
6 years	0	0	0	0	2	1	**3**	**2%**
7 years	0	0	0	0	1	1	**2**	**1%**
8 years	1	0	0	0	1	1	**3**	**2%**
9 years	0	0	0	0	0	7	**7**	**4%**
10 years	0	0	0	0	1	0	**1**	**1%**
11 years	0	0	0	0	2	3	**5**	**3%**
12 years	0	1	0	0	1	1	**3**	**2%**
13 years	0	1	0	0	0	2	**3**	**2%**
14 years	2	0	1	0	3	2	**8**	**5%**
15 years	2	1	0	0	0	1	**4**	**2%**
16 years	5	4	1	1	3	1	**15**	**9%**
17 years	6	1	0	0	5	1	**13**	**8%**
18 or older	1	2	0	0	1	0	**4**	**2%**
Total	**22**	**10**	**24**	**8**	**37**	**62**	**163**	**100%**

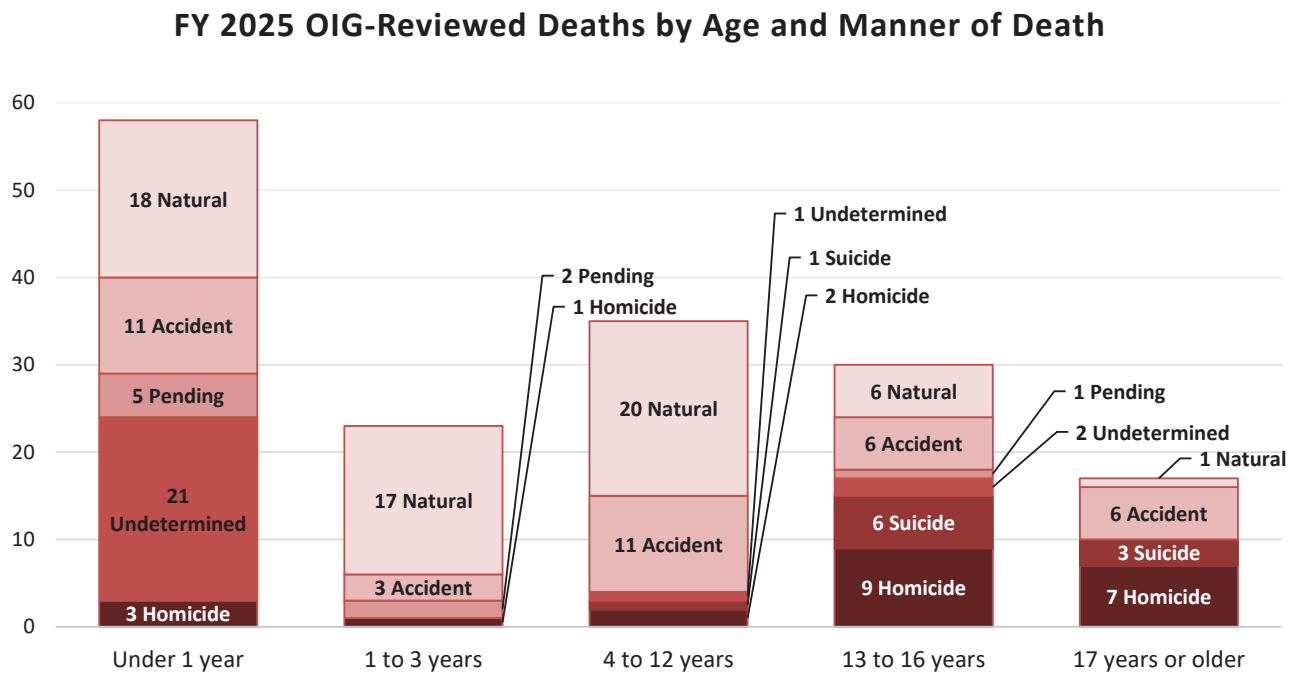


Table 2: Child Deaths by Primary Reason for OIG Review and Manner of Death								
Primary Reason for OIG Review*	**Homicide**	**Suicide**	**Undetermined**	**Pending**	**Accident**	**Natural**	**Total**	**Percent**
Pending DCP	6	0	8	1	3	5	**23**	**14%**
Unfounded DCP	8	3	7	3	16	19	**56**	**34%**
Indicated DCP	1	0	1	0	3	4	**9**	**6%**
Youth in Care	3	2	0	2	5	10	**22**	**13%**
Former Youth in Care	0	0	1	0	0	0	**1**	**1%**
Return Home/Closed Placement	1	0	0	0	1	1	**3**	**2%**
Open Placement/Split Custody	0	0	0	0	1	2	**3**	**2%**
Open Intact	1	1	2	0	3	13	**20**	**12%**
Closed Intact	0	0	1	1	2	1	**5**	**3%**
Child of Youth in Care	0	0	1	0	0	0	**1**	**1%**
Child Welfare Services Referral	2	4	3	1	3	7	**20**	**12%**
Total	**22**	**10**	**24**	**8**	**37**	**62**	**163**	**100%**

*When more than one reason existed for OIG investigation, the death was categorized based on the primary involvement.

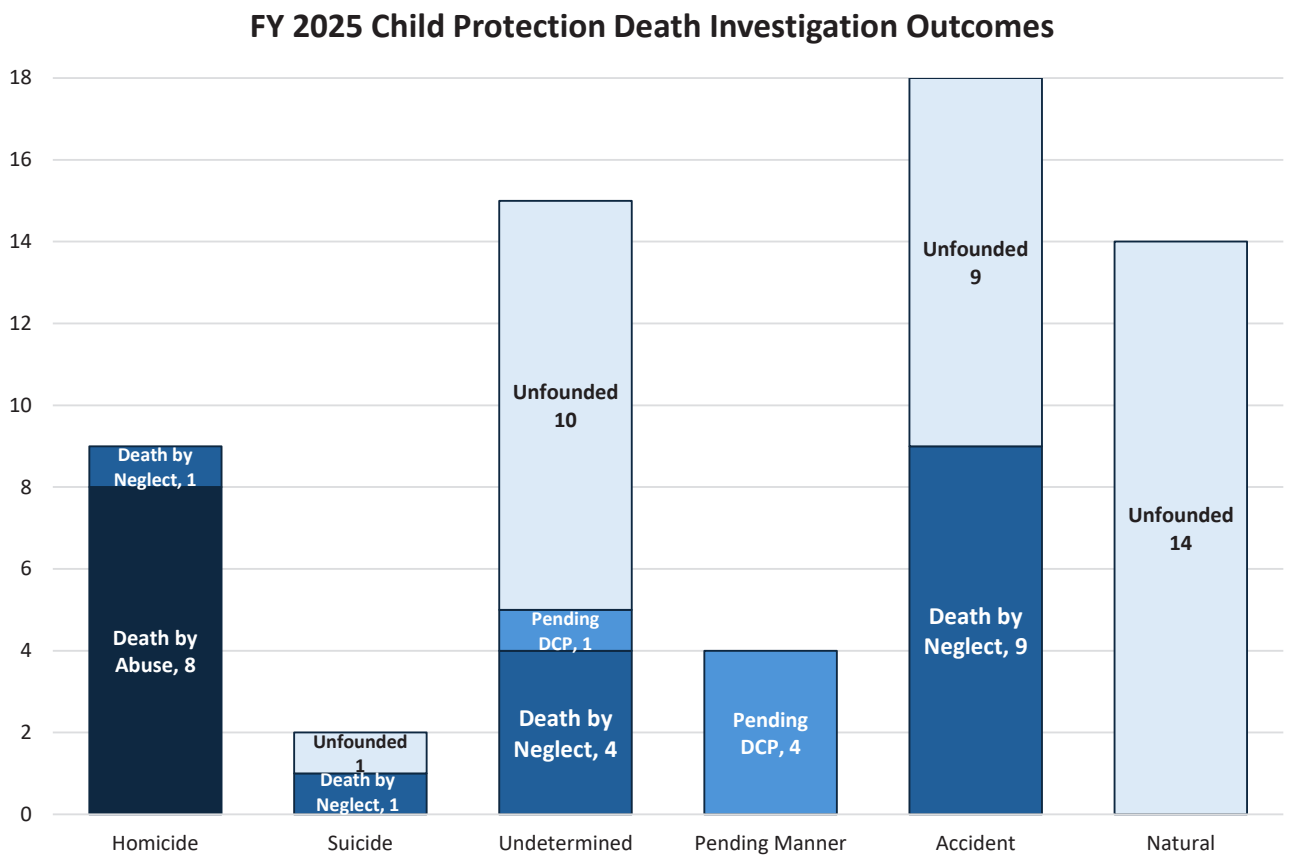
Key for Reason for Review table

Reason for Review	**Definition**
Youth in Care	Deceased was a youth in care
Unfounded DCP	Family had an unfounded child protection investigation within a year of child's death
Pending DCP	Family was involved in a pending child protection investigation at time of child's death
Indicated DCP	Family had an indicated child protection investigation within a year of child's death
Child of Youth in Care	Deceased was the child of a youth in care, but not in care themselves
Open Intact	Family had an open intact family services case at time of child's death
Closed Intact	Family had an intact family services case that closed within a year of child's death
Open Placement/ Split Custody	Deceased, who never went home from the hospital after birth, and had siblings(s) in foster care; or child was in care of parent with siblings in foster care
Return Home/ Closed Placement	Deceased or sibling(s) returned home to parent(s) from foster care within a year of child's death, or siblings of deceased adopted within a year of child's death
Child Welfare Services Referral	A request was made for DCFS to provide services, but no abuse or neglected was alleged
Former Youth in Care	Child was a youth in care within a year of their death

Table 3: Child Deaths by Region of Residence and Manner of Death								
Region	**Homicide**	**Suicide**	**Undetermined**	**Pending**	**Accident**	**Natural**	**Total**	**Percent**
Central	3	5	4	0	9	16	**37**	**23%**
Cook	9	4	10	6	6	16	**51**	**31%**
Northern	7	1	8	1	14	17	**48**	**29%**
Southern	3	0	2	1	8	13	**27**	**17%**
Total	**22**	**10**	**24**	**8**	**37**	**62**	**163**	**100%**

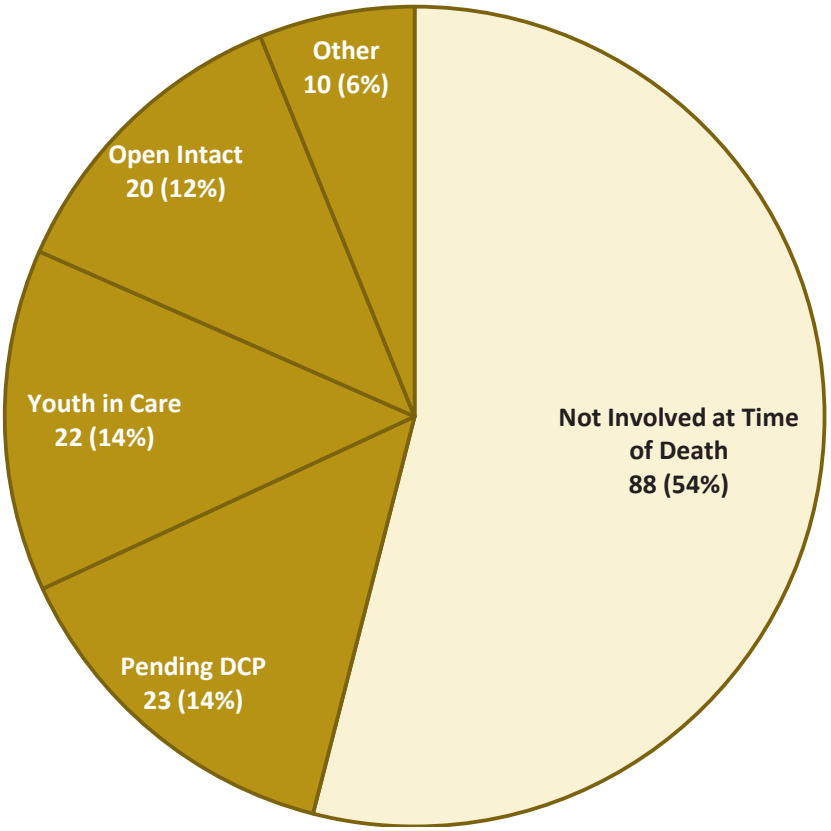
Table 4: Child Protection Death Investigations by Result and Manner								
Final Finding	**Homicide**	**Suicide**	**Undetermined**	**Pending Manner**	**Accident**	**Natural**	**Total**	**Percent**
Indicated: Death by abuse (#1)*	8	0	0	0	0	0	**8**	**13%**
Indicated: Death by neglect (#51)*	1	1	4	0	9	0	**15**	**24%**
Pending Investigation	0	0	1	4	0	0	**5**	**8%**
Unfounded	0	1	10	0	9	14	**34**	**55%**
Total	**9**	**2**	**15**	**4**	**18**	**14**	**62**	**100%**

*Child deaths in which one person was indicated or unfounded for death by abuse or death by neglect. Note that persons indicated for death will remain on the State Central Register for 50 years.



Of the 163 child deaths the OIG reviewed, 75 (46%) of the children's families had current open/pending involvement at the time of the child's death. Of the 75 child deaths with current open/pending involvement, 23 (31%) had a pending child protection investigation, 22 (29%) were youth in care, and 20 (27%) had open intact family services cases. The remaining 10 (13%) had an open child welfare services referral, open placement or split custody case, open placement services case following return home, or were the child of a youth in care.

Child Deaths with Open Involvement at Time of Death



Homicide

Twenty-two deaths were ruled as homicide in the manner of death by coroners, medical examiners, or pronouncing physicians.

Cause of Death	Number	Percent
Blunt force injuries	1	5%
Drug toxicity	1	5%
Gunshot wound(s)	13	59%
Head Injuries	3	14%
Multiple injuries	3	14%
Strangulation	1	5%
Total	**22**	**100%**

Homicide Category	Number	Percent
Child Abuse	8	36%
Child Neglect	1	5%
Domestic Homicide	2	9%
Street Homicide	11	50%
Total	**22**	**100%**

Perpetrator*	Number	Percent
Mother	5	23%
Father	3	14%
Parent's Paramour/Stepparent	3	14%
Sibling	1	5%
Unrelated	3	14%
Unknown	9	41%
Child's boyfriend/girlfriend	1	5%

*Some deaths may have more than one perpetrator.

See page 35 for summaries of deaths by homicide.

Suicide

Ten deaths were ruled as suicide in the manner of death by coroners, medical examiners, or pronouncing physicians.

Cause of Death	Number	Percent
Blunt force injuries	2	20%
Drug toxicity	1	10%
Gunshot wound(s)	2	20%
Hanging	3	30%
Motor vehicle accident	1	10%
Traumatic brain injury	1	10%
Total	**10**	**100%**

See page 43 for summaries of deaths by suicide.

Undetermined

Twenty-four deaths were ruled as undetermined in the manner of death by coroners, medical examiners, or pronouncing physicians.

Cause of death	Number	Percent
Asphyxia (sleep related)	1	4%
Blunt force injuries	1	4%
Drug toxicity	1	4%
Gunshot wound(s)	1	4%
SUID	1	4%
SUID or undetermined (sleep related)	17	71%
Undetermined	2	8%
Total	**24**	**100%**

See page 45 for summaries of deaths by undetermined manner.

Accident

Thirty-seven deaths were ruled as an accident in the manner of death by coroners, medical examiners, or pronouncing physicians.

Cause of death	Number	Percent
Asphyxiation	2	6%
Carbon monoxide toxicity	1	3%
Drowning	6	17%
Drug toxicity	6	17%
Extreme temperature exposure	2	6%
Gunshot wound(s)	1	3%
Hanging	1	3%
Head injuries	1	3%
Injuries from house fire	3	8%
Motor vehicle accident	4	11%
Nutritional deficiencies	1	3%
Sleep-related	9	22%
Total	**37**	**100%**

See page 57 for summaries of accidental deaths.

Natural

Sixty-two deaths were ruled as natural in the manner of death by coroners, medical examiners, or pronouncing physicians.

Cause of death	Number	Percent
Cancer	8	13%
Cardiac disease complications	4	6%
Complications of multiple medical complexities	6	10%
Congenital disorder complications	12	19%
Neurological condition complications	4	6%
Pneumonia, sepsis, viral infection, or bacterial infection	13	21%
Prematurity complications	4	6%
Respiratory condition complications	7	11%
SUID	2	3%
Traumatic injuries	1	2%
Undetermined	1	2%
Total	**62**	**100%**

See page 68 for summaries of natural deaths.

HOMICIDE

Child No. 1	DOB: 05/2008	DOD: 07/2024	Homicide

Age at death: 16 years
Cause of death: Complications of multiple injuries due to assault
Alleged perpetrator: Unrelated peer
DCFS investigation: No child protection investigation of death
Reason for review: Youth in care; closed intact family services case and indicated child protection investigation within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: The teen's family had an intact family services case that had been open for one year. Ten months before the teen's death, DCFS opened a child protection investigation against the teen's father, the teen came into DCFS care and the intact case closed. Nine months before the teen's death, DCFS indicated the teen's father for medical neglect (#79) and lock out (#84). The teen remained in DCFS care. The worker's last contact with the teen was a month prior to the teen's death when the teen was moved to a group home. The teen eloped from the group home twice within the last month prior to the teen's death. The teen eloped from the group home again two days prior to the assault that led to the teen's death.

Child No. 2	DOB: 04/2009	DOD: 08/2024	Homicide

Age at death: 15 years
Cause of death: Multiple gunshot wounds
Alleged perpetrator: Unknown (street homicide)
DCFS investigation: No child protection investigation of death
Reason for review: Pending child protection investigation at time of child's death
OIG action taken: Investigatory review of records

Reason for review: One month before the teen's death, DCFS opened a child protection investigation against the teen's mother. The investigation remained pending at the time of the teen's death. DCFS later unfounded the teen's mother for environmental neglect (#82) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Prior to the teen's death, the CPS last saw the family during a home visit five weeks before the teen's death.

Child No. 3	DOB: 10/2015	DOD: 08/2024	Homicide

Age at death: 8 years
Cause of death: Complications of remote traumatic brain injury due to child abuse
Alleged perpetrator: Mother and father
DCFS investigation: Mother and father indicated for death by abuse (#1)
Reason for review: Youth in care
OIG action taken: Investigatory review of records

Reason for review: The child came into DCFS care when she was 2 months old after she sustained permanently disabling child abuse injuries, which eventually led to her death. Her placement worker last visited her 11 days before her death.

Child No. 4	DOB: 07/2008	DOD: 09/2024	Homicide

Age at death: 16 years
Cause of death: Complications of gunshot wounds
Alleged perpetrator: Unknown (street homicide)
DCFS investigation: No child protection investigation of death
Reason for review: Unfounded child protection investigation within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Two months before the teen's death, DCFS opened a child protection investigation against the teen's grandmother. A month later, DCFS unfounded the grandmother for inadequate supervision (#74). The CPS's last contact with the family occurred two weeks before the investigation closed, when the CPS met with the family in person.

Child No. 5	DOB: 08/2024	DOD: 09/2024	Homicide

Age at death: 6 weeks
Cause of death: Cocaine intoxication
Alleged perpetrator: Mother
DCFS investigation: Mother indicated for death by abuse (#1)
Reason for review: Pending child protection investigation at time of child's death
OIG action taken: Investigatory review of records

Reason for review: Ten days before the infant's death, DCFS opened a child protection investigation against the infant's mother. The investigation remained pending at the time of the death. DCFS later indicated the infant's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS's last contact with the family occurred three days before the infant's death, when the CPS spoke with the mother by phone.

Child No. 6	DOB: 11/2006	DOD: 09/2024	Homicide

Age at death: 17 years
Cause of death: Complications of remote gunshot wound of neck
Alleged perpetrator: Unknown
DCFS investigation: No child protection investigation of death
Reason for review: Pending child protection investigation at time of child's death
OIG action taken: Investigatory review of records

Reason for review: Five months before the teen's death, DCFS opened a child protection investigation against the teen's mother and father. The investigation remained pending at the time of the death. DCFS later unfounded the mother and father for sexual exploitation (#20) and environmental neglect (#82). The CPS last saw the teen's sibling during a forensic interview a month before the teen's death.

Child No. 7	DOB: 10/2008	DOD: 10/2024	Homicide

Age at death:	16 years
Cause of death:	Strangulation
Alleged perpetrator:	Teen's boyfriend
DCFS investigation:	No child protection investigation of death
Reason for review:	One indicated and one unfounded child protection investigation within one year of child's death
OIG action taken:	Full investigation; report submitted to Director in FY 2026

Reason for review: Five months before the teen's death, DCFS opened a child protection investigation against the teen and her boyfriend. Approximately two months later, DCFS indicated the teen and her boyfriend for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to their infant daughter. Three days after the previous investigation opened, while it was still pending, DCFS opened a separate investigation against the teen's mother and stepfather. Two months later, DCFS unfounded the teen's mother and stepfather for sexual molestation (#21) and substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the teen, and unfounded both parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the teen's siblings. The CPS last met with the mother and siblings two days before the investigation closed.

Child No. 8	DOB: 12/2023	DOD: 10/2024	Homicide

Age at death:	10 months
Cause of death:	Multiple injuries due to child abuse
Alleged perpetrator:	Mother and mother's paramour
DCFS investigation:	Mother and mother's paramour indicated for death by abuse (#1)
Reason for review:	Three unfounded child protection investigations and one child welfare services referral within one year of child's death
OIG action taken:	Investigatory review of records

Reason for review: Over a year before the infant's death, DCFS opened a child protection investigation against the infant's mother. Four months before the infant's death, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and cuts, bruises, welts, abrasions, and oral injuries by neglect (#61) to the child's sibling. One year before the infant's death, while the previous child protection investigation remained pending, DCFS opened a new child protection investigation against the infant's mother and her paramour. Four months before the infant's death, the same day the prior child protection investigation closed, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and unfounded the mother's paramour for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the infant's sibling. The CPS last had contact with the mother the day before the child protection investigations closed, during a visit to the home. Nine months before the infant's death, while the prior two child protection investigations remained pending, DCFS opened another child protection investigation against the infant's mother. Eight months before the infant's death, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the infant's sibling, and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant and his sibling. One month before the infant's death, DCFS opened a child welfare services referral for the family. The referral remained open at the time of the child's death, but the CWS worker was unable to locate the family.

Child No. 9	DOB: 04/2007	DOD: 10/2024	Homicide

Age at death: 17 years
Cause of death: Multiple gunshot wounds
Alleged perpetrator: Unknown (street homicide)
DCFS investigation: No child protection investigation of death
Reason for review: Youth in care and pending child protection investigation at time of child's death
OIG action taken: Investigatory review of records

Reason for review: The teen came into DCFS care in 2019, when he was 11 years old. Approximately eight months before his death, DCFS opened a child protection investigation against the teen's fictive kin foster mother. The investigation remained pending at the time of the teen's death. DCFS later unfounded the fictive kin foster mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The teen's placement worker last met with him two weeks before his death.

Child No. 10	DOB: 09/2010	DOD: 11/2024	Homicide

Age at death: 14 years
Cause of death: Seizure disorder due to abusive head trauma
Alleged perpetrator: Birth mother and birth mother's paramour
DCFS investigation: Birth mother and birth mother's paramour indicated for death by abuse (#1)
Reason for review: Open intact family services case at time of child's death; two indicated child protection investigations within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Seven months before the medically complex teen's death, which was due to complications of the earlier abuse by the teen's birth mother and birth mother's paramour, DCFS closed a child protection investigation against the teen's adoptive father that had been open for over a year. DCFS indicated an unknown perpetrator for medical neglect (#79) as the teen had multiple caregivers, and DCFS unfounded the adoptive father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11); medical neglect (#79); and environmental neglect (#82). Six months before the teen's death, DCFS opened a child protection investigation against the teen's adoptive mother and father. Two months before the teen's death, DCFS indicated the adoptive parents for medical neglect (#79) and opened an intact family services case for the family. The intact case remained open at the time of the teen's death. The intact worker last saw the family three days before the teen's death, during a visit to the home.

Child No. 11	DOB: 11/2020	DOD: 11/2024	Homicide

Age at death: 4 years
Cause of death: Partial evisceration of brain and skull fractures and subarachnoid hemorrhage due to single gunshot wound to right side of forehead
Alleged perpetrator: Sibling
DCFS investigation: Mother and father indicated for death by neglect (#51)
Reason for review: Return home, one indicated child protection investigation, and four unfounded child protection investigations within one year of child's death
OIG action taken: Full investigation pending

Reason for review: Eight months before the child's death, DCFS opened a child protection investigation against the child's mother. Five months before the child's death, DCFS unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the child's sibling. Six months before the child's death, while the previous investigation remained pending, DCFS opened a child protection investigation against the child's mother and father. Approximately five months before the child's death,

DCFS indicated the mother and father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the child's sibling, and indicated the mother and father for cuts, bruises, welts, abrasions, and oral injuries by neglect (#61) to the child and his siblings. The day after the investigation opened, the children came into the care of DCFS. Three months before the death, the court returned the children to their parents' care, and the placement case remained open for aftercare services. Two months before the child's death, DCFS opened a child protection investigation against the child's mother and father. Three weeks before the child's death, DCFS unfounded the mother and father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and cuts, bruises, welts, abrasions, and oral injuries by neglect (#61) to one sibling, and unfounded the mother and father for inadequate supervision (#74) to the child and his siblings. Three weeks after the prior investigation opened, while it remained pending, DCFS opened another investigation against the child's mother and father. One month before the child's death, DCFS unfounded the mother and father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the child's sibling. Five days after the investigation closed, DCFS opened a new investigation against the child's mother and father. Approximately three weeks before the child's death, DCFS unfounded the mother and father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the child's sibling. The placement worker's last contact with the family prior to the child's death was a visit to the home two days earlier.

Child No. 12	DOB: 08/2024	DOD: 11/2024	Homicide
Age at death:	2 months		
Cause of death:	Abusive head trauma acute		
Alleged perpetrator:	Father		
DCFS investigation:	Father indicated for death by abuse (#1)		
Reason for review:	Pending child protection investigation at time of child's death and unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Four months before the infant's birth, seven months before her death, DCFS closed a child protection investigation against the mother that had been open for five months; DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). One month after the infant's birth, DCFS opened a child protection investigation against the infant's mother and father. The investigation remained pending at the time of the infant's death. DCFS later indicated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS last saw the family during a home visit one month before the infant's death.

Child No. 13	DOB: 01/2010	DOD: 12/2024	Homicide
Age at death:	14 years		
Cause of death:	Gunshot wound to chest		
Alleged perpetrator:	Unknown (street homicide)		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: One month before the teen's death, DCFS opened a child protection investigation against the teen's mother. The following week, DCFS also opened a child protection investigation against the teen's brother. Three weeks later, DCFS unfounded the teen's brother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). The investigation against the teen's mother remained pending at the time of the teen's death. DCFS later unfounded the teen's mother for cuts, bruises, welts, abrasions,

and oral injuries by abuse (#11). The CPS's last contact with the family prior to the teen's death occurred two weeks before the death, when the CPS met with the teen's siblings at school.

Child No. 14	DOB: 07/2007	DOD: 12/2024	Homicide

Age at death: 17 years
Cause of death: Gunshot wound to the head
Alleged perpetrator: Unknown (street homicide)
DCFS investigation: No child protection investigation of death
Reason for review: Unfounded child protection investigation within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Seven months before the teen's death, DCFS opened a child protection investigation against the teen's mother. One month later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82) to the teen and his siblings. The CPS's last contact with the family occurred one week before the investigation closed, when the CPS visited the family at home.

Child No. 15	DOB: 03/2008	DOD: 12/2024	Homicide

Age at death: 16 years
Cause of death: Complications of gunshot wounds of head, neck and torso
Alleged perpetrator: Unknown
DCFS investigation: No child protection investigation of death
Reason for review: Unfounded child protection investigation within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Nine months before the teen's death, DCFS opened a child protection investigation against the teen's father. Two months later, DCFS unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS's last contact with the family occurred the day before the investigation closed, when the CPS met with the teen at school and met with the father at home.

Child No. 16	DOB: 07/2008	DOD: 01/2025	Homicide

Age at death: 16 years
Cause of death: Complications of multiple blunt force traumatic injuries of the head, torso, genitals and extremities with extensive thermal injuries of the skin; significant contributing factor of malnutrition
Alleged perpetrator: Stepfather
DCFS investigation: Mother and stepfather indicated for death by abuse (#1)
Reason for review: One unfounded child protection investigation within one year of child's death
OIG action taken: Full investigation pending

Reason for review: Two months before the teen's death, DCFS opened a child protection investigation against the teen's stepfather. Six weeks before the teen's death, DCFS unfounded the stepfather for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the teen. The CPS last met with the family two weeks before the child protection investigation closed, during an in-person visit.

Child No. 17	DOB: 05/2008	DOD: 02/2025	Homicide

Age at death: 16 years
Cause of death: Multiple gunshot wounds
Alleged perpetrator: Unrelated adult (street homicide)
DCFS investigation: No child protection investigation of death
Reason for review: Unfounded child protection investigation and child welfare services referral within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Eleven months before the teen's death, DCFS opened a child protection investigation against the teen's mother. One week later, DCFS unfounded the teen's mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and substance misuse by abuse (#15) to the then 15-year-old teen and his 14-year-old brother. Nine months before the teen's death, DCFS opened a child welfare services referral for the family. The CWS worker last made successful contact with the mother by phone approximately three weeks later. Four months before the teen's death, the child welfare services referral closed.

Child No. 18	DOB: 07/2009	DOD: 02/2025	Homicide

Age at death: 15 years
Cause of death: Gunshot wound of the head
Alleged perpetrator: Father
DCFS investigation: Father indicated for death by abuse (#1)
Reason for review: Child welfare services referral within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Less than two weeks before the teen's death, DCFS opened a child welfare services referral. One week before the teen's death, the CWS worker spoke with the teen's father, who declined to allow the CWS worker to meet with the children. Four days before the teen's death, DCFS closed the child welfare services referral.

Child No. 19	DOB: 10/2006	DOD: 03/2025	Homicide

Age at death: 18 years
Cause of death: Multiple gunshot wounds
Alleged perpetrator: Unknown (street homicide)
DCFS investigation: No child protection investigation of death
Reason for review: Child welfare services referral within one year of youth's death
OIG action taken: Investigatory review of records

Reason for review: Nine months before the youth's death, DCFS opened a child welfare services referral for the family. The CWS worker last spoke with the youth's mother three days after the referral opened. The child welfare services referral closed the following month.

Child No. 20	DOB: 06/2007	DOD: 04/2025	Homicide

Age at death: 17 years
Cause of death: Gunshot wound of back
Alleged perpetrator: Unknown
DCFS investigation: No child protection investigation of death
Reason for review: Pending child protection investigation at time of child's death; child welfare services referral within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Eleven months before the teen's death, DCFS opened a child welfare services referral for the family. The referral closed ten days later after the mother declined services. Three weeks before the teen's death, DCFS opened a child protection investigation against the teen's mother. The investigation remained pending at the time of the teen's death. DCFS later unfounded the teen's mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the teen. The CPS's last contact with the family occurred four days before the teen's death, when the CPS visited the home and met with the family.

Child No. 21	DOB: 02/2008	DOD: 04/2025	Homicide

Age at death: 17 years
Cause of death: Multiple gunshot wounds
Alleged perpetrator: Unknown (street homicide)
DCFS investigation: No child protection investigation of death
Reason for review: Two unfounded child protection investigations within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Eleven months before the teen's death, DCFS opened a child protection investigation against the teen's mother. One month later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the teen. One month before the teen's death, DCFS opened another child protection investigation against the teen's mother. Less than two weeks later, DCFS again unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS last had contact six days before the investigation closed, during a visit to the school to interview the teen.

Child No. 22	DOB: 08/2023	DOD: 05/2025	Homicide

Age at death: 21 months
Cause of death: Blunt force trauma due to abuse
Alleged perpetrator: Mother
DCFS investigation: Mother indicated for death by abuse (#1)
Reason for review: One unfounded child protection investigation within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Seven months before the toddler's death, DCFS opened a child protection investigation against the toddler's mother. Two months later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler and his siblings. The CPS last had contact with the family two weeks before the investigation closed, during a visit with the mother and children at daycare.

Child No. 23	DOB: 05/2006	DOD: 09/2024	Suicide

Age at death: 18 years
Cause of death: Hanging
DCFS investigation: No child protection investigation of death
Reason for review: Youth in care; unfounded child protection investigation within one year of youth's death
OIG action taken: Investigatory review of records

Reason for review: The youth came into DCFS care when he was 13 years old. Ten months before the youth's death, DCFS opened a child protection investigation against the youth's foster parent, his grandmother. Seven months before the youth's death, DCFS unfounded the youth's grandmother for environmental neglect (#82). The youth remained in care at the time of his death. The youth's placement worker last saw him two months before his death, during an in-person visit at the youth's residential placement.

Child No. 24	DOB: 02/2012	DOD: 01/2025	Suicide

Age at death: 12 years
Cause of death: Gunshot wound of abdomen
DCFS investigation: Mother indicated for death by neglect (#51)
Reason for review: Child welfare services referral within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Three months before the child's death, DCFS opened a child welfare services referral for the family. Six days later, the CWS worker met with the family at home. The child welfare services referral closed the following week.

Child No. 25	DOB: 08/2005	DOD: 03/2025	Suicide

Age at death: 19 years
Cause of death: Gunshot wound of the head
DCFS investigation: No child protection investigation of death
Reason for review: Youth in care
OIG action taken: Investigatory review of records

Reason for review: The youth came into DCFS care approximately eight years before his death, when he was 11 years old. The youth's placement worker last met with him in person six days before his death.

Child No. 26	DOB: 03/2009	DOD: 03/2025	Suicide

Age at death: 16 years
Cause of death: Hanging
DCFS investigation: No child protection investigation of death
Reason for review: Child welfare services referral within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Six months before the teen's death, DCFS opened a child welfare services referral for the family. The child welfare services referral closed one month later. The CWS worker last had contact with the teen's 13-year-old brother six days after the referral opened.

Child No. 27	DOB: 06/2008	DOD: 04/2025	Suicide
Age at death:	16 years		
Cause of death:	Multiple traumatic injuries due to minivan striking a fixed object		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Four months before the teen's death, DCFS opened a child protection investigation against the teen's father. Ten days later, DCFS unfounded the father for inadequate food (#76) to the teen. The CPS's last contact with the family occurred the day the investigation opened, during a home visit.

Child No. 28	DOB: 05/2011	DOD: 05/2025	Suicide
Age at death:	13 years		
Cause of death:	Hanging		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Approximately two months before the teen's death, DCFS opened a child welfare services referral for the family. Three weeks later, the referral closed. DCFS last had contact with the family during a phone call three days before the referral closed, when the mother declined services.

Child No. 29	DOB: 08/2008	DOD: 05/2025	Suicide
Age at death:	16 years		
Cause of death:	Multiple blunt force injuries		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Five months before the teen's death, DCFS opened a child protection investigation against the teen's father. Three months later, DCFS unfounded the father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). The CPS last met with the family during a home visit three days before the investigation closed.

Child No. 30	DOB: 01/2009	DOD: 06/2025	Suicide
Age at death:	16 years		
Cause of death:	Traumatic brain injury		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Approximately four months before the teen's death, DCFS opened a child protection against the teen's stepfather. Two months later, DCFS unfounded the stepfather for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the teen. The CPS's last contact with the family occurred two days before the investigation closed, when the CPS met with the teen at home.

Child No. 31	DOB: 08/2007	DOD: 06/2025	Suicide

Age at death: 17 years
Cause of death: Multiple blunt force injuries
DCFS investigation: No child protection investigation of death
Reason for review: Open intact family services case at time of child's death; one unfounded child protection investigation within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Two months before the teen's death, DCFS opened a child protection investigation against the teen's mother. Three weeks later, DCFS unfounded the teen's mother for environmental neglect (#82) to the teen and her cousin. Before the investigation closed, DCFS opened an intact family services case for the teen's mother, which remained open at the time of the teen's death. The intact worker last had contact with the family one week before the teen's death, during a visit to the home.

Child No. 32	DOB: 02/2010	DOD: 06/2025	Suicide

Age at death: 15 years
Cause of death: Combined toxic effects of diphenhydramine and fluoxetine
DCFS investigation: Mother unfounded for death by neglect (#51)
Reason for review: Child welfare services referral within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Three weeks before the teen's death, DCFS opened a child welfare services referral for the family. One week before the teen's death, the referral closed after the family declined services. The CWS worker's last contact with the family occurred one week after the referral opened, during a visit to the home.

UNDETERMINED

Child No. 33	DOB: 07/2020	DOD: 07/2024	Undetermined

Age at death: 4 years
Cause of death: Multiple blunt force injuries due to fall from height
DCFS investigation: Mother indicated for death by neglect (#51)
Reason for review: Pending child protection investigation at time of child's death; two unfounded child protection investigations within one year of child's death
OIG action taken: Included in pending systemic issue report

Reason for review: Eight months before the child's death, DCFS opened a child protection investigation against the child's mother. Three months before the child's death, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the child and his sibling. Two weeks later, DCFS opened a new child protection investigation against the child's mother. One month before the child's death, DCFS unfounded the mother for inadequate supervision (#74) to the child and his sibling. Three months before the child's death, while the previous investigation remained pending, DCFS opened another child protection investigation against the child's mother. The investigation remained pending at the time of the child's death. DCFS later indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the child and his sibling but unfounded her for inadequate food (#76) and medical neglect (#79) to the child and his sibling. The CPS's last contact prior to the serious injury that led to the child's death occurred five weeks earlier, when the CPS spoke with the mother by phone.

Child No. 34	DOB: 01/2024	DOD: 07/2024	Undetermined

Age at death: 6 months
Cause of death: Undetermined
DCFS investigation: Father unfounded for death by neglect (#51)
Reason for review: Unfounded child protection investigation within one year of child's death
OIG action taken: Full investigation pending

Reason for review: The day the infant was born, DCFS opened a child protection investigation against the infant's mother. Two months later, DCFS unfounded the infant's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS's last contact with the family occurred one week before the investigation closed, when the CPS met with the family at home.

Child No. 35	DOB: 09/2024	DOD: 09/2024	Undetermined

Age at death: 5 days
Cause of death: Sudden unexpected infant death
DCFS investigation: No child protection investigation of death
Reason for review: Open intact family services case at time of child's death; indicated child protection investigation within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: One year before the newborn's birth, DCFS opened a child protection investigation against the newborn's mother. Nine months before the newborn's birth and death, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Before the child protection investigation closed, DCFS opened an intact family services case for the family. The intact case remained open at the time of the newborn's death. The intact worker last had contact with the family the day before the newborn's birth, during a home visit.

Child No. 36	DOB: 05/2024	DOD: 09/2024	Undetermined

Age at death: 3 months
Cause of death: Unexplained sudden death (intrinsic and extrinsic factors identified)
DCFS investigation: Mother indicated for death by neglect (#51)
Reason for review: Child welfare services referral within year of child's death
OIG action taken: Investigatory review of records

Reason for review: The day after the infant's birth, DCFS opened a child welfare services referral for the family. Two months before the infant's death, DCFS closed the referral. The CWS worker was unable to successfully contact the family.

Child No. 37	DOB: 08/2024	DOD: 09/2024	Undetermined

Age at death: 4 weeks
Cause of death: Undetermined
DCFS investigation: No child protection investigation of death
Reason for review: Two unfounded child protection investigations within one year of child's death
OIG action taken: Full investigation pending

Reason for review: Ten months before the infant's death, DCFS opened a child protection investigation against the infant's mother and father. Seven months before the infant's death, DCFS unfounded the mother for substantial risk of sexual abuse (#22) to the infant's sibling and unfounded both the mother and father for environmental neglect (#82) to the infant's siblings. Three months before the infant's

death, DCFS opened a new investigation against the infant's mother. Six weeks before the infant's death, DCFS unfounded the mother for burns by abuse (#5) to the infant's sibling.

Child No. 38	DOB: 07/2024	DOD: 10/2024	Undetermined
Age at death:	2 months		
Cause of death:	Sudden unexpected infant death		
DCFS investigation:	Mother unfounded for death by neglect (#51)		
Reason for review:	Pending child protection investigation at time of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Two weeks before the infant's death, DCFS opened a child protection investigation against the child's mother. The investigation remained pending at the time of the infant's death. DCFS later unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS's last contact with the family before the infant's death was a home visit one day earlier.

Child No. 39	DOB: 01/2024	DOD: 10/2024	Undetermined
Age at death:	8 months		
Cause of death:	Undetermined		
DCFS investigation:	Pending child protection investigation of death		
Reason for review:	Open intact family services case at time of child's death; two indicated and two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: The infant's family had an intact family services case that had been open for over two years before the infant's death. Three months before the infant's birth, and one year before his death, DCFS opened a child protection investigation against the infant's paternal grandmother. One month later, DCFS unfounded the paternal grandmother for inadequate supervision (#74). Five months before the infant's death, DCFS opened a child protection investigation against the infant's paternal grandmother and paternal grandfather. Three months before the infant's death, DCFS indicated the paternal grandmother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), but unfounded the paternal grandfather for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). One week before the prior investigation closed, DCFS opened a child protection investigation against the infant's father. Approximately two months before the infant's death, DCFS unfounded the father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11); sexual exploitation (#20), and substantial risk of sexual abuse (#22). Two days before that investigation closed, DCFS opened another child protection investigation against the infant's mother and father. One month before the infant's death, DCFS indicated the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and indicated both the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The intact family services case remained open at the time of the infant's death. The intact worker's last contact with the family before the infant's death occurred three weeks earlier, when the intact worker met with the family at home.

Child No. 40	DOB: 02/2008	DOD: 10/2024	Undetermined
Age at death:	16 years		
Cause of death:	Non-contact gunshot wound to the left upper chest		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Ten months before the teen's death, DCFS opened a child protection investigation against the paramour of the teen's father. Approximately nine months before the teen's death, DCFS unfounded the father's paramour for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). Six months before the teen's death, DCFS opened a child protection investigation against the teen's father. Two months before the teen's death, DCFS unfounded the father for inadequate supervision (#74) and inadequate food (#76) to the teen. The CPS last had contact with the family two days before the investigation closed, during a visit with the family in the community.

Child No. 41	DOB: 08/2024	DOD: 10/2024	Undetermined
Age at death:	2 months		
Cause of death:	Unexplained sudden death (extrinsic factors identified)		
DCFS investigation:	Mother and father unfounded for death by neglect (#51)		
Reason for review:	Child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Three days after the infant's birth, DCFS opened a child welfare services referral for the infant's family. One month before the infant's death, the referral closed. The CWS worker last met with the family the day the referral closed.

Child No. 42	DOB: 09/2024	DOD: 11/2024	Undetermined
Age at death:	2 months		
Cause of death:	Undetermined		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child of a youth in care		
OIG action taken:	Investigatory review of records		

Reason for review: The infant's mother came into care seven years before the infant's death, and she remained in care at the time of his death. Prior to the death, the mother's placement worker last had contact with her ten days earlier, when the placement worker visited the mother and infant at home.

Child No. 43	DOB: 10/2024	DOD: 11/2024	Undetermined
Age at death:	5 weeks		
Cause of death:	Sudden unexplained infant death; significant contributing factor of fentanyl exposure due to maternal chronic narcotism		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Pending child protection investigation at time of child's death; two indicated child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eleven months before the infant's birth, one year before her death, DCFS opened a child protection investigation against her mother. Eight months before the infant's birth, ten months

before her death, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Seven months before the infant's birth, eight months before her death, DCFS opened another child protection investigation against the infant's mother. Five months before the infant's birth and six months before her death, DCFS indicated the infant's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Two days after the infant's birth, one month before her death, DCFS opened a new investigation against the infant's mother. The investigation remained pending at the time of the infant's death. DCFS later unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS's last contact with the family prior to the death was a phone call with the infant's maternal grandmother earlier in the day, on the day the infant died.

Child No. 44	DOB: 10/2024	DOD: 11/2024	Undetermined
Age at death:	6 weeks		
Cause of death:	Undetermined		
DCFS investigation:	Mother and father unfounded for death by abuse (#1)		
Reason for review:	Pending child protection investigation at time of child's death; one unfounded child protection investigation within one year of child's death		
OIG action taken:	Included in pending systemic issue report		

Reason for review: Eleven months before the infant's death, DCFS unfounded a child protection investigation that had been opened approximately three months earlier against the infant's father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant's sibling. Eight months before the infant's death, DCFS opened a child protection investigation against the infant's mother and father. The investigation remained pending at the time of the infant's death. DCFS later indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant's siblings, but unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the siblings. The CPS last had contact with the family approximately two weeks before the infant's death when she met with the family at the grandmother's home.

Child No. 45	DOB: 07/2024	DOD: 11/2024	Undetermined
Age at death:	4 months		
Cause of death:	Undetermined		
DCFS investigation:	Mother and father unfounded for death by neglect (#51)		
Reason for review:	Pending child protection investigation at time of child's death; two indicated and one unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Ten months before the infant's death, DCFS opened a child protection investigation against the mother and maternal grandmother of the infant's paternal half-brother. Three weeks later, DCFS unfounded the investigation for substantial risk of sexual abuse (#22). The day after that investigation opened, DCFS opened a second investigation against the maternal grandmother of the infant's paternal half-brother. Eight months before the infant's death, while the investigation remained pending, the mother of the infant's paternal half-brother died. Seven months before the infant's death, DCFS indicated the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) but unfounded the investigation for substantial risk of sexual abuse (#22). Two months before the infant's death, DCFS opened an investigation against the maternal grandmother of the infant's paternal half-brother. During the investigation, the father took custody of the paternal half-brother. Less than two weeks later, DCFS indicated the investigation for inadequate supervision (#74). One month before the

infant's death, DCFS opened an investigation against the father. The investigation remained pending at the time of the infant's death. DCFS later unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). The CPS's last contact with the family before the infant's death was a home visit four weeks earlier.

Child No. 46	DOB: 08/2024	DOD: 12/2024	Undetermined
Age at death:	4 months		
Cause of death:	Unexplained sudden death (extrinsic factors identified)		
DCFS investigation:	Mother unfounded for death by neglect (#51)		
Reason for review:	Three unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Seven months before the infant's birth, eleven months before her death, DCFS opened a child protection investigation against the infant's mother and the father of the infant's siblings. Two month later, DCFS unfounded the mother and father of the siblings for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). One week later, DCFS opened another child protection investigation against the infant's mother and father. Four months before the infant's birth, eight months before her death, DCFS unfounded the infant's mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Three months before the infant's birth, seven months before her death, while the previous investigation remained pending, DCFS opened another child protection investigation against the infant's mother and father. One month before the infant's birth, five months before her death, DCFS unfounded the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS's last contact with the family occurred one month before the investigation closed, when the CPS met with the father.

Child No. 47	DOB: 08/2024	DOD: 12/2024	Undetermined
Age at death:	3 months		
Cause of death:	Sudden unexpected infant death		
DCFS investigation:	Mother and father indicated for death by neglect (#51)		
Reason for review:	Pending child protection investigation at time of child's death; child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Three weeks before the infant's birth, DCFS opened a child protection investigation against the infant's mother and father. The investigation remained pending at the time of the infant's death. DCFS later indicated both parents for inadequate supervision (#74). One week after the infant's birth, while the child protection investigation remained pending, DCFS opened a child welfare services referral for the family. The CWS referral closed one month later with no action needed. The CWS worker's last contact with the family prior to the infant's death occurred approximately three weeks after the CWS referral opened, when the CWS worker met with the family at home.

Child No. 48	DOB: 11/2024	DOD: 01/2025	Undetermined
Age at death:	5 weeks		
Cause of death:	Sudden unexplained infant death		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child of a former youth in care		
OIG action taken:	Investigatory review of records		

Reason for review: The infant's mother had been a youth in care for eight years, and she aged out of care approximately three months before the infant's birth. The mother's placement worker last met with the mother during a home visit five days before her placement case closed.

Child No. 49	DOB: 02/2025	DOD: 02/2025	Undetermined
Age at death:	4 days		
Cause of death:	Consistent with sudden unexplained death in infancy		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Ten months before the newborn's death, DCFS closed a child protection investigation involving the family that had been open for approximately two months. DCFS unfounded the newborn's mother for inadequate supervision (#74) to the newborn's siblings, and unfounded the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the siblings. Ten days after the investigation closed, DCFS opened another child protection investigation against the mother and father. Eight months before the newborn's death, DCFS unfounded the mother and father for inadequate supervision (#74) and environmental neglect (#82) to the newborn's siblings. The CPS last had contact with the family during a home visit five days before the investigation closed.

Child No. 50	DOB: 10/2024	DOD: 03/2025	Undetermined
Age at death:	5 months		
Cause of death:	Asphyxia due to unsafe sleeping with a blanket and adult bedding		
DCFS investigation:	Mother and father unfounded for death by neglect (#51)		
Reason for review:	Pending child protection investigation at time of child's death; two unfounded child protection investigations and one child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: One year before the infant's death, DCFS opened a child protection investigation against the infant's mother. Ten months before the infant's death, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the infant's sibling. Approximately three weeks before the previous investigation closed, DCFS opened a separate child protection investigation against the infant's mother. Eight months before the infant's death, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to one sibling and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to another sibling. The day after the infant's birth, DCFS opened a child welfare services referral for the mother. The referral closed approximately seven weeks later after services were provided. Six weeks before the infant's death, DCFS opened a new child protection investigation against the infant's father and mother. The investigation remained pending at the time of the infant's death. DCFS later unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the infant and unfounded the mother for environmental neglect (#82) to

the infant and his siblings. The CPS's last contact with the family prior to the infant's death occurred six days earlier, when the CPS spoke with the mother by phone.

Child No. 51	DOB: 12/2024	DOD: 03/2025	Undetermined
Age at death:	3 months		
Cause of death:	Undetermined		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Over one year before the infant's death, DCFS opened a child protection investigation against the infant's father. Eleven months before the infant's death, DCFS unfounded the father for sexual penetration (#19) to the father's niece. The CPS last had contact with the father during a phone call the day the investigation closed.

Child No. 52	DOB: 02/2025	DOD: 03/2025	Undetermined
Age at death:	5 weeks		
Cause of death:	Undetermined		
DCFS investigation:	Pending child protection investigation of death		
Reason for review:	Two pending child protection investigations at time of child's death; closed intact family services case, one indicated child protection investigation, and one unfounded child protection investigation within one year of child's death		
OIG action taken:	Full investigation pending		

Reason for review: Seven months before the infant's death, DCFS closed a child protection investigation against several adult family members that had opened approximately six months earlier involving the infant's sibling and two cousins. DCFS indicated the grandmother for sexual exploitation (#20) but unfounded the infant's mother and aunt for sexual exploitation (#20). DCFS unfounded the infant's aunt and grandfather for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). DCFS unfounded the infant's grandmother and grandfather for environmental neglect (#82). DCFS unfounded the infant's grandmother for inadequate supervision (#74). DCFS unfounded another aunt for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). The next day, DCFS closed a child protection investigation against one of the infant's aunts, who lived in the family home, that had opened six months earlier. DCFS unfounded the aunt for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to her child. Eight months before the infant's death, while the child protection investigations remained pending, DCFS opened an intact family services case for the infant's grandparents, an aunt, and the aunt's children. Less than two months later, the intact family services case closed unsuccessfully after the family became uncooperative with services. Four months before the infant's death, DCFS opened a child protection investigation against the infant's grandmother, which remained pending at the time of the infant's death. DCFS later unfounded the grandmother for inadequate supervision (#74) to the infant's cousin. Ten days before the infant's death, DCFS opened a child protection investigation against the infant's mother and grandmother, which also remained pending at the time of the infant's death. DCFS later indicated the infant's mother and grandmother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant and his cousins. DCFS unfounded the mother and grandmother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the infant and his cousins. The CPS last had contact with the family six days before the infant's death, during a visit with the children at their grandfather's home.

Child No. 53	DOB: 01/2011	DOD: 06/2025	Undetermined
Age at death:	14 years		
Cause of death:	Bronchopneumonia due to fentanyl intoxication		
DCFS investigation:	Uncle indicated for death by neglect (#51)		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: One year before the teen's death, DCFS opened a child protection investigation against the teen's mother. Eleven months before the teen's death, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82) to the teen's half-siblings. The CPS's last contact with the family was a home visit the day after the investigation opened.

Child No. 54	DOB: 05/2025	DOD: 06/2025	Undetermined
Age at death:	2 weeks		
Cause of death:	Undetermined		
DCFS investigation:	Mother unfounded for death by neglect (#51)		
Reason for review:	One indicated child protection investigation within one year of child's death and pending child welfare services referral at time of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Nine months before the newborn's death, DCFS opened a child protection investigation against the newborn's mother and father. Two months later, DCFS indicated the newborn's mother and father for environmental neglect (#82) to the newborn's siblings. The CPS last had contact with the family the day the investigation closed, during a visit to the home. Two days after the newborn's birth, DCFS opened a child welfare services referral for the family, which remained pending at the time of the newborn's death. The CWS worker never made successful contact with the family prior to the newborn's death.

Child No. 55	DOB: 04/2025	DOD: 06/2025	Undetermined
Age at death:	2 months		
Cause of death:	Undetermined		
DCFS investigation:	Mother and father unfounded for death by neglect (#51)		
Reason for review:	Closed intact family services case and one indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eleven months before the infant's death, DCFS opened a child protection investigation against the child's mother and father. Two months later, DCFS indicated the mother and father for head injuries by abuse (#2) to the infant's sibling. Ten months before the infant's death, while the child protection investigation was pending, DCFS opened an intact family services case for the family. Three months before the infant's birth, five months before the infant's death, the intact family services case closed after the parents made satisfactory progress. The intact worker last met with the family two weeks before the intact family services case closed.

Child No. 56	DOB: 06/2025	DOD: 06/2025	Undetermined

Age at death: 3 days
Cause of death: Undetermined
DCFS investigation: No child protection investigation of death
Reason for review: Pending child welfare services referral at time of child's death
OIG action taken: Investigatory review of records

Reason for review: The day after the newborn's birth, DCFS opened a child welfare services referral for the family. The referral remained open at the time of the newborn's death two days later. The CWS worker did not make contact with the family prior to the newborn's death.

PENDING

Child No. 57	DOB: 06/2022	DOD: 01/2025	Pending

Age at death: 2 years
Cause of death: Pending
DCFS investigation: No child protection investigation of death
Reason for review: Child was a youth in care; one indicated child protection investigation within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Six months before the toddler's death, DCFS opened an investigation against the toddler's mother and father. That day, the toddler and her siblings came into care of DCFS. Three months later, DCFS indicated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10); cuts, bruises, welts, abrasions, and oral injuries by abuse (#11); and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler and her siblings. The placement worker's last contact with the family occurred two days before the toddler's death, when the placement worker spoke with the mother by phone.

Child No. 58	DOB: 03/2024	DOD: 01/2025	Pending

Age at death: 9 months
Cause of death: Pending
DCFS investigation: Pending child protection investigation for death
Reason for review: Child welfare services referral within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: One month before the infant's birth, DCFS opened a child welfare services referral for the family. One month later, DCFS closed the referral. The CWS worker last had contact with the family the day before the referral closed, during a home visit.

Child No. 59	DOB: 04/2024	DOD: 02/2025	Pending
Age at death:	10 months		
Cause of death:	Pending		
DCFS investigation:	Pending child protection investigation of death		
Reason for review:	One unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eight months before the infant's death, DCFS opened a child protection investigation against the infant's mother and father. Two months later, DCFS unfounded the mother and father for inadequate shelter (#77) to the infant. The CPS last had contact with the family the day before the investigation closed, during a visit to the home.

Child No. 60	DOB: 06/2008	DOD: 03/2025	Pending
Age at death:	16 years		
Cause of death:	Pending		
DCFS investigation:	No child protection investigation of death		
Reason for review:	One unfounded child protection investigation within one year of child's death		
OIG action taken:	Full investigation pending		

Reason for review: Ten months before the teen's death, DCFS closed a child protection investigation that had been opened three months earlier against the teen's mother. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the teen and her siblings. The CPS last had contact with the family the day after the investigation opened during a visit at the school to interview the children.

Child No. 61	DOB: 07/2024	DOD: 04/2025	Pending
Age at death:	8 months		
Cause of death:	Pending		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Closed intact family services case and two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: One week after the infant's birth, DCFS closed an intact family services case as successful that had been open for five months. Seven months before the infant's death, DCFS opened a child protection investigation against the infant's mother. Three months before the infant's death, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#10) to the infant's sibling. Two months before the infant's death, DCFS opened another child protection investigation against the infant's mother. Three weeks before the infant's death, DCFS unfounded the mother for inadequate supervision (#74), inadequate food (#76), and inadequate clothing (#78) to the infant's sibling. The CPS last met with the family one day before the investigation closed, during a visit to the home.

Child No. 62	DOB: 03/2025	DOD: 05/2025	Pending
Age at death:	6 weeks		
Cause of death:	Pending		
DCFS investigation:	Pending child protection investigation of death		
Reason for review:	Child was a youth in care; one indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: The day of the infant's birth, DCFS opened a child protection investigation against the infant's mother. Four weeks later, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant. During the investigation, DCFS took protective custody of the infant, and the baby remained in care of DCFS until his death. The placement worker's last contact with the family occurred the day before the infant's death during a scheduled parent visit at the agency office.

Child No. 63	DOB: 04/2025	DOD: 05/2025	Pending
Age at death:	4 weeks		
Cause of death:	Pending		
DCFS investigation:	No child protection investigation of death		
Reason for review:	One unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Five months before the infant's death, four months before his birth, DCFS opened a child protection investigation against the infant's mother and stepfather. One month later, DCFS unfounded the mother and stepfather for inadequate clothing (#78) and environmental neglect (#82) to the infant's siblings. The CPS's last contact with the family occurred the day after the investigation opened, during a visit to the home.

Child No. 64	DOB: 09/2021	DOD: 06/2025	Pending
Age at death:	3 years		
Cause of death:	Pending		
DCFS investigation:	Pending child protection investigation of death		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation		
OIG action taken:	Full investigation pending		

Reason for review: Six months before the toddler's death, DCFS opened a child protection investigation against the toddler's mother. Approximately two months before the toddler's death, DCFS unfounded the child's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60); cuts, bruises, welts, abrasions, and oral injuries by neglect (#61); and inadequate shelter (#77). Approximately one month before the toddler's death, DCFS opened a child protection investigation against the toddler's father. The investigation remained pending at the time of the child's death. The CPS's last contact with the family prior to the serious injury that led to the toddler's death occurred one week after the investigation opened, when the CPS met with the mother and observed the toddler at home. DCFS later unfounded the father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

ACCIDENT

Child No. 65	DOB: 05/2024	DOD: 07/2024	Accident
Age at death:	8 weeks		
Cause of death:	Unexplained sudden death due to unsafe sleep environment		
DCFS investigation:	Mother unfounded for death by neglect (#51)		
Reason for review:	Child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Two days after the infant's birth, DCFS opened a child welfare services referral for the family. The CWS worker met with the mother six days later. The child welfare services referral closed that day.

Child No. 66 Child No. 67	DOB: 10/2012 DOB: 04/2008	DOD: 07/2024 DOD: 07/2024	Accident Accident
Age at death:	Child No. 66 - 11 years		
Age at death:	Child No. 67 - 16 years		
Cause of death:	Blunt force injuries due to motor vehicle mishap		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of children's deaths		
OIG action taken:	Included in systemic issue report; report to Director on June 30, 2025 **See Death and Serious Injury Investigation 4**		

Reason for review: Fourteen months before the children's deaths, DCFS opened a child protection investigation against the children's adult brother. Eight months before the deaths, DCFS unfounded the brother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). The CPS's last contact with the family occurred 14 months before the children's deaths, when the CPS met with the mother and children at home.

Child No. 68	DOB: 02/2023	DOD: 07/2024	Accident
Age at death:	17 months		
Cause of death:	Hyperthermia due to environmental heat exposure		
DCFS investigation:	Mother indicated for death by neglect (#51)		
Reason for review:	Split custody		
OIG action taken:	Full investigation pending		

Reason for review: The toddler had five siblings who were youth in care, and they had begun to enter DCFS care six years earlier. At the time of the toddler's death, the siblings remained in care, while the toddler and his 3-year-old sibling remained in their mother's home. The Department's last contact with the family occurred approximately two weeks before the toddler's death, when the placement worker met with the siblings who were in care.

Child No. 69	DOB: 11/2017	DOD: 07/2024	Accident
Age at death:	6 years		
Cause of death:	Drowning		
DCFS investigation:	Mother unfounded for death by neglect (#51)		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
OIG action taken:	Full investigation pending		

Reason for review: Nine months before the child's death, DCFS opened a child protection investigation against an unknown perpetrator. Approximately two months later, DCFS unfounded the investigation for burns by abuse (#5). Three months before the child's death, DCFS opened an investigation against the paramour of the child's mother. Approximately two months later, DCFS unfounded the paramour for inadequate supervision (#74) to the child's sibling. The CPS's last contact with the family occurred the day the investigation closed, when the CPS met with the family at home.

Child No. 70	DOB: 11/2011	DOD: 07/2024	Accident
Age at death:	12 years		
Cause of death:	Drowning		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Closed intact family services case, indicated child protection investigation, and unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: In the year before the child's death, the family had an intact family services case. Eight months before the child's death, DCFS opened a child protection investigation against the child's mother and father. Six months before the death, DCFS indicated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) but unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). Five months before the child's death, DCFS closed the intact family services case unsuccessfully after it had been open for nine months. Three months before the child's death, DCFS opened another child protection investigation against the mother and father. Three days before the child's death, DCFS unfounded the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS last had contact with the family three days before the child's death, during a home visit.

Child No. 71	DOB: 02/2021	DOD: 07/2024	Accident
Age at death:	3 years		
Cause of death:	Drowning		
DCFS investigation:	Father indicated for death by neglect (#51)		
Reason for review:	Open intact family services case at time of child's death, and indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Four months before the toddler's death, DCFS opened a child protection investigation against the toddler's father. Three months before the toddler's death, while the child protection investigation was open, DCFS opened an intact family services case for the family. Two months before the toddler's death, DCFS indicated the toddler's father for inadequate supervision (#74). At the time of the toddler's death, the intact family services case had been open for three months and remained open. The intact worker last saw the family three weeks before the toddler's death, during a home visit.

Child No. 72	DOB: 08/2019	DOD: 07/2024	Accident
Age at death:	4 years		
Cause of death:	Drowning		
DCFS investigation:	Mother and father indicated for death by neglect (#51)		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Two weeks before the child's death, DCFS unfounded a child protection investigation against the child's mother for inadequate supervision (#74). The CPS last had contact with the mother by phone ten days before the investigation closed.

Child No. 73	DOB: 07/2024	DOD: 08/2024	Accident
Age at death:	3 weeks		
Cause of death:	Asphyxia due to overlaying and co-sleeping in an adult bed with soft bedding		
DCFS investigation:	Mother unfounded for death by neglect (#51)		
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Approximately two months before the newborn's birth and three months before his death, DCFS opened a child protection investigation against the newborn's mother and maternal grandmother to the newborn's sibling. Approximately two weeks after the newborn's birth, while the child protection investigation remained open, DCFS opened an intact family services case for the family. Both the child protection investigation and intact family services case remained open at the time of the newborn's death. DCFS later unfounded the child's mother and maternal grandmother for substantial risk of sexual abuse (#22) and unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The family's last contact with DCFS prior to the newborn's death occurred the day of the death, when the CPS spoke with the newborn's father by phone.

Child No. 74	DOB: 04/2024	DOD: 08/2024	Accident
Age at death:	3 months		
Cause of death:	Asphyxia due to suffocation due to prone facedown sleeping position in a u-shaped infant pillow on foam mattress		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Approximately five months before the infant's death, DCFS opened a child protection investigation against the infant's father. Three months before the infant's death, DCFS unfounded the father for inadequate supervision (#74). The CPS last saw the family the day the investigation closed, at the mother's home.

Child No. 75	DOB: 10/2009	DOD: 09/2024	Accident
Age at death:	14 years		
Cause of death:	Combined effects of fluoxetine and clonidine		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Youth in care		
OIG action taken:	Investigatory review of records		

Reason for review: The teen came into care when she was 9 years old. The placement worker last met with the teen in person six days before her death.

Child No. 76	DOB: 12/2017	DOD: 09/2024	Accident
Age at death:	6 years		
Cause of death:	Carbon monoxide intoxication due to inhalation of smoke and soot due to residential house fire		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Youth in care		
OIG action taken:	Investigatory review of records		

Reason for review: The child had been a youth in care for approximately two years prior to her death. The placement worker last had contact with the family one week before the child's death, when the placement worker visited the foster home.

Child No. 77	DOB: 03/2007	DOD: 10/2024	Accident
Age at death:	17 years		
Cause of death:	Multi-system organ failure due to anoxic encephalopathy due to hanging		
DCFS investigation:	Mother indicated for death by neglect (#51) due to injuries child sustained at 4 years old		
Reason for review:	Youth in care		
OIG action taken:	Investigatory review of records		

Reason for review: The teen had been a youth in care since she was five years old. The placement worker last visited the teen four days before her death.

Child No. 78	DOB: 08/2014	DOD: 10/2024	Accident
Age at death:	10 years		
Cause of death:	Asphyxia due to choking due to food bolus; significant contributing factors of seizure disorder, Lennox Gestaut syndrome		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Five months before the child's death, DCFS opened a child protection investigation against his father. Approximately two months later, DCFS unfounded the father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the child's sibling. The CPS last had contact with the family two days before the investigation closed, during a visit to the home.

Child No. 79	DOB: 10/2007	DOD: 10/2024	Accident
Age at death:	17 years		
Cause of death:	Combined drug (3,4-methylenedioxymethamphetamine (MDMA), amphetamine and alprazolam) toxicity		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Approximately two months before the teen's death, DCFS opened an investigation against the teen's father. Two weeks later, DCFS unfounded the father for substance misuse by neglect (#65) to the teen. The day after the investigation opened, DCFS opened a new child protection investigation against the teen's mother and stepfather. One week later, DCFS unfounded the mother and stepfather for inadequate supervision (#74) to the teen. DCFS last had contact with the family in the earlier child protection investigation, when the CPS spoke with the father by phone.

Child No. 80	DOB: 06/2024	DOD: 11/2024	Accident
Age at death:	4 months		
Cause of death:	Hypoxic ischemic encephalopathy due to positional asphyxiation due to unsafe sleep environment		
DCFS investigation:	Mother and father unfounded for death by neglect (#51)		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Three months before the infant's death, DCFS opened an investigation against the infant's mother and father. One month later, DCFS unfounded the mother and father for inadequate food (#76) to the infant. The CPS last spoke with the parents by phone the day before the investigation closed.

Child No. 81	DOB: 08/2024	DOD: 11/2024	Accident
Age at death:	2 months		
Cause of death:	Sudden unexpected infant death with co-sleeping		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: The day after the infant's birth, DCFS opened a child welfare services referral for the family. One month before the infant's death, the referral closed. The CWS worker last had contact with the mother by phone the day the referral closed.

Child No. 82	DOB: 05/2024	DOD: 11/2024	Accident
Age at death:	6 months		
Cause of death:	Asphyxia due to prone sleeping position while co-sleeping with siblings on a beanbag bed		
DCFS investigation:	Mother and father indicated for death by neglect (#51)		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Five months before the infant's birth, eleven months before his death, DCFS opened an investigation against the infant's mother. Three months before the infant's birth, nine months

before his death, DCFS unfounded the mother for inadequate food (#76) and environmental neglect (#82). Three months before the infant's death, DCFS opened another investigation against the infant's mother. One month before the infant's death, DCFS unfounded the mother for medical neglect (#79). The CPS last met with the family at home six weeks before the investigation closed.

Child No. 83	DOB: 01/2010	DOD: 11/2024	Accident
Age at death:	14 years		
Cause of death:	Multiple blunt force injuries due to motor vehicle striking fixed object		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eight months before the teen's death, DCFS opened an investigation against the teen's mother. Less than two months later, DCFS indicated the teen's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the teen's brother. The CPS last met with the family three weeks before the investigation closed, during a visit to the home.

Child No. 84	DOB: 11/2024	DOD: 12/2024	Accident
Age at death:	5 weeks		
Cause of death:	Hypoxic ischemic encephalopathy due to positional asphyxia due to unsafe sleep environment		
DCFS investigation:	Uncle unfounded for death by neglect (#51)		
Reason for review:	Closed intact family services case and closed child welfare services referral within one year of child's death		
OIG action taken:	Full investigation pending		

Reason for review: The family had an intact family services case that was open over a year before the infant's birth. Six months before the infant's birth, after nine months of services, the intact family services case closed successfully. The intact worker's last contact with the family occurred two days before the intact case closed, when the intact worker completed a closing visit with the family. Two weeks before the infant's birth, DCFS opened a child welfare services referral for the family. The referral closed one week later, after the CWS worker made multiple unsuccessful attempts to meet with the family.

Child No. 85	DOB: 09/2008	DOD: 12/2024	Accident
Age at death:	16 years		
Cause of death:	Adverse effects of fentanyl and para-flourofentanyl		
DCFS investigation:	Mother and father indicated for death by neglect (#51)		
Reason for review:	Pending child protection investigation at time of child's death; one indicated child protection investigation and one child welfare services referral within one year of child's death		
OIG action taken:	Full investigation pending		

Reason for review: Approximately eight months before the teen's death, DCFS opened a child welfare services referral for the family. The CWS referral closed the following month with a referral to another state agency for services. Seven months before the teen's death, DCFS opened a child protection investigation against the teen's mother and father. Two months before the teen's death, DCFS indicated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and substance misuse by neglect (#65) to the teen. DCFS unfounded the parents for

environmental neglect (#82). Five months before the teen's death, while the prior investigation remained pending, DCFS opened a new child protection investigation against the teen's mother and father. The investigation remained pending at the time of the teen's death. DCFS later indicated the mother for substance misuse by neglect (#65) to the teen and indicated both the mother and father for inadequate supervision (#74) to the teen. The CPS last had contact with the family two months before the teen's death, during a visit with the teen and his grandmother at the parents' home.

Child No. 86	DOB: 08/2024	DOD: 12/2024	Accident
Age at death:	3 months		
Cause of death:	Positional asphyxia due to unsafe sleep environment		
DCFS investigation:	Father unfounded for death by neglect (#51)		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Two months before the infant's death, DCFS opened a child protection investigation against the child's parents. One week before the infant's death, DCFS unfounded both parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS last met with the family at a home visit two weeks before the infant's death.

Child No. 87	DOB: 05/2007	DOD: 01/2025	Accident
Age at death:	17 years		
Cause of death:	Adverse effects of ethanol		
DCFS investigation:	No child protection investigation of death		
Reason for review:	One unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Nine months before the teen's death, DCFS opened a child protection investigation against the teen's father, the teen's cousin, and a perpetrator with an unknown relationship to the family. Two months later, DCFS unfounded all three adults for human labor trafficking (#40) to the teen and the teen's siblings, cousins, and alleged child victims whose relationship to the teen is unknown. The CPS's last contact with the family occurred two weeks before the investigation closed, when the CPS met with some of the alleged child victims at school.

Child No. 88 Child No. 89	DOB: 07/2017 DOB: 04/2013	DOD: 02/2025 DOD: 02/2025	Accident Accident
Age at death:	Child No. 88 - 7 years		
Age at death:	Child No. 89 - 11 years		
Cause of death:	Thermal burns and smoke inhalation		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of children's deaths		
OIG action taken:	Investigatory review of records		

Reason for review: Nine months before the children's deaths, DCFS opened a child protection investigation against the children's mother. Seven months before the children's deaths, DCFS unfounded the mother for environmental neglect (#82) to the then 6-year-old child. The CPS last met with the family at their home on the day the investigation closed.

Child No. 90	DOB: 03/2024	DOD: 02/2025	Accident
Age at death:	10 months		
Cause of death:	Drowning		
DCFS investigation:	Mother indicated for death by neglect (#51)		
Reason for review:	Return home within one year of child's death; closed intact family services case at time of child's death; two indicated child protection investigations and one unfounded child protection investigation within one year of child's death		
OIG action taken:	Included in pending systemic issue report		

Reason for review: The family had an intact family services case that opened four months before the infant's birth. One week after the infant's birth, DCFS opened a child protection investigation against the infant's mother. One month later, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Three weeks after the infant's birth, DCFS opened a child protection investigation against the infant's mother and father. Two months later, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant and environmental neglect (#82) to the infant's siblings; indicated both parents for medical neglect (#79) to the infant's sibling; and indicated the infant's father for substantial risk of sexual abuse (#22) to the infant's sibling. DCFS unfounded allegations of inadequate supervision (#74) and environmental neglect (#82). Three weeks after the infant's birth, while the child protection investigations were pending, DCFS took protective custody of the infant and his siblings. Five months later, three of the children were returned to their mother's care, including the infant. One week after the children were returned home, DCFS opened another child protection investigation against the infant's mother. One month later, three months before the infant's death, DCFS unfounded the infant's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Two months before the infant's death, the fourth sibling returned to the mother's care. The placement case remained open for aftercare services at the time of the infant's death. The family's last contact with the placement worker occurred two weeks before the infant's death, when the placement worker met with the family at home.

Child No. 91	DOB: 02/2006	DOD: 02/2025	Accident
Age at death:	18 years		
Cause of death:	Cold exposure; significant contributing factors of methamphetamine intoxication and mental disorder		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Youth in care; one unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: The youth came into DCFS care five years before his death, when he was 13 years old. Approximately two months before the youth's death, DCFS initiated an investigation involving the youth's cousin, against a different relative, for an incident that allegedly took place at the grandmother's home, where the youth was residing. Four days before the youth's death, DCFS unfounded the other relative for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). The Department's last contact with the youth occurred one week before his death, when the CPS visited the grandmother's home.

Child No. 92	DOB: 09/2007	DOD: 03/2025	Accident
Age at death:	17 years		
Cause of death:	Carbon monoxide toxicity due to inhalation of automobile exhaust from running vehicle		
DCFS investigation:	No child protection investigation of death		
Reason for review:	One indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Ten months before the teen's death, DCFS closed a child protection investigation against the paramour of the teen's mother which had been open for two months. DCFS indicated the paramour for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the teen's sibling but unfounded the paramour for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the teen. The CPS last had contact with the family one week before the investigation closed, during a visit to the home.

Child No. 93	DOB: 04/2008	DOD: 03/2025	Accident
Age at death:	16 years		
Cause of death:	Fentanyl and methamphetamine intoxication		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Pending child protection at time of child's death; two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eleven months before the teen's death, DCFS closed and unfounded a child protection investigation that had been open for two months against the teen's father for sexual exploitation (#20) to the teen's brother. Six months before the teen's death, DCFS opened a child protection investigation against an alleged caregiver. Two months before the teen's death, DCFS unfounded the alleged perpetrator for inadequate supervision (#74) to the teen. The CPS last had contact with the teen approximately two months before the investigation closed, during an in-person visit. Three weeks before the teen's death, DCFS opened a child protection investigation against the teen's father. The investigation remained pending at the time of the teen's death. DCFS later unfounded the father for inadequate supervision (#74) to the teen. The CPS was unable to locate the teen prior to his death.

Child No. 94	DOB: 09/2016	DOD: 03/2025	Accident
Age at death:	8 years		
Cause of death:	Gunshot wound to the head		
DCFS investigation:	Father indicated for death by neglect (#51)		
Reason for review:	One unfounded child protection investigation and one child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Seven months before the child's death, DCFS opened a child protection investigation against the child's uncle. Two months later, DCFS unfounded the uncle for inadequate supervision (#74) to the child and his siblings. The CPS's last contact with the family occurred two days after the investigation opened, when the CPS met with the mother and children at home. Five months before the child's death, while the child protection investigation remained pending, DCFS opened a child welfare services referral for the family. The referral was closed three days later because the family was already involved in a pending child protection investigation.

Child No. 95	DOB: 01/2021	DOD: 03/2025	Accident
Age at death:	4 years		
Cause of death:	Drowning		
DCFS investigation:	Mother unfounded for by death by neglect (#51)		
Reason for review:	Child was a youth in care; one indicated and one unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: The child came into DCFS care when she was 14 months old, and she remained a youth in care at the time of her death. Over one year before the child's death, DCFS opened an investigation against the child's mother, father, and grandmother for incidents occurring during visitation. Eleven months before the child's death, DCFS indicated the mother and grandmother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the child and her siblings, indicated the father and grandmother for inadequate supervision (#74) to the child and her siblings. Ten months before the child's death, DCFS opened a new child protection investigation against the child's mother and father. Seven months before the child's death, DCFS unfounded the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the child and her siblings. The child remained a youth in care but was placed in her mother's care one month before her death. The placement worker last met with the child, her siblings, and her mother at home over a week before the death.

Child No. 96	DOB: 09/2007	DOD: 04/2025	Accident
Age at death:	17 years		
Cause of death:	Combined drug (fentanyl, despropionyl, fentanyl [4-ANPP], alprazolam) toxicity		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Three indicated and two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Ten months before the teen's death, DCFS opened a child protection investigation against the teen's parents. Three weeks later, DCFS indicated the mother and father for medical neglect (#79) to the teen. Seven months before the teen's death, DCFS opened another child protection investigation against the teen's parents. Five months before the teen's death, DCFS indicated the teen's mother and father for inadequate supervision (#74). Five months before the teen's death, while the previous investigation remained pending, DCFS opened another child protection investigation against the teen's parents. Four months before the teen's death, DCFS indicated the teen's mother and father for substance misuse by neglect (#65) to the teen. Three months before the teen's death, DCFS opened a child protection investigation against the teen's father. Approximately two months before the teen's death, DCFS unfounded the father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the teen. One week later, DCFS opened another child protection investigation against the teen's father. Approximately three weeks before the teen's death, DCFS unfounded the teen's father for inadequate supervision (#74) to the teen. The CPS's last contact with the family occurred five days before the investigation closed, when the CPS interviewed the teen's sibling at school.

Child No. 97	DOB: 09/2010	DOD: 04/2025	Accident

Age at death: 14 years
Cause of death: Multiple blunt force injuries following a motor vehicle collision
DCFS investigation: No child protection investigation of death
Reason for review: Pending child protection investigation at time of child's death
OIG action taken: Investigatory review of records

Reason for review: Approximately two months before the teen's death, DCFS opened a child protection investigation against the teen's father. The investigation remained pending at the time of the teen's death. DCFS later unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the teen and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the teen and his siblings. The CPS's last contact with the family prior to the teen's death occurred three weeks earlier, during a visit to the home.

Child No. 98	DOB: 12/2024	DOD: 05/2025	Accident

Age at death: 5 months
Cause of death: Cardiopulmonary arrest due to positional asphyxia
DCFS investigation: Mother and father indicated for death by neglect (#51)
Reason for review: Pending child welfare services referral at time of child's death
OIG action taken: Investigatory review of records

Reason for review: Two weeks before the infant's death, DCFS opened a child welfare services referral for the infant's family. The referral remained open at the time of the infant's death. The CWS worker did not have any documented contact with the family before the infant's death.

Child No. 99	DOB: 12/2020	DOD: 05/2025	Accident

Age at death: 4 years
Cause of death: Traumatic head injury
DCFS investigation: No child protection investigation of death
Reason for review: One unfounded child protection investigation within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Approximately eleven months before the child's death, DCFS closed a child protection investigation against the child's father. DCFS indicated the father for sexual molestation (#21) to the child's sibling and substantial risk of sexual abuse (#22) to the child and another sibling. The investigation was later unfounded on appeal. The CPS's last contact with the family occurred approximately two weeks before the investigation closed, when the CPS met with the family at home.

Child No. 100	DOB: 04/2023	DOD: 06/2025	Accident

Age at death: 2 years
Cause of death: Positional asphyxiation
DCFS investigation: Mother unfounded for death by neglect (#51)
Reason for review: One unfounded child protection investigation within one year of child's death
OIG action taken: Investigatory review of records

Reason for review: Three months before the toddler's death, DCFS opened a child protection investigation against the toddler's mother and father. Six weeks later, DCFS unfounded the mother and father for environmental neglect (#82) to the toddler and her siblings. The CPS's last contact with the family occurred one week before the investigation closed, when the parents sent a message to the CPS.

Child No. 101	DOB: 03/2025	DOD: 06/2025	Accident
Age at death:	2 months		
Cause of death:	Severe hypernatremia due to ingesting overconcentrated infant formula		
DCFS investigation:	Mother unfounded for death by neglect (#51)		
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death; one indicated child protection investigation and child welfare services referral within one year of child's death		
OIG action taken:	Included in pending systemic issue report		

Reason for review: Two months before the infant's death, DCFS opened a child welfare services referral for the family. The referral closed three days later, after DCFS opened a child protection investigation against the mother. Seven weeks before the infant's death, while the child protection investigation remained pending, DCFS opened an intact family services case, which remained open at the time of the infant's death. Three weeks before the infant's death, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant. Four days later, DCFS opened a new child protection investigation against the infant's mother. The investigation remained pending at the time of the infant's death. DCFS later indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and medical neglect (#79) to the infant, but unfounded her for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the infant. Following the infant's death, DCFS added an allegation of death by neglect (#51) to the investigation, but the mother was unfounded for the allegation. The CPS's last contact with the family prior to the infant's death occurred the day before the death when the CPS met with the family at their home.

NATURAL

Child No. 102	DOB: 06/2024	DOD: 07/2024	Natural
Age at death:	3 weeks		
Cause of death:	Interstitial and bronchopneumonia		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Open intact family services case at time of death; indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Four months before the newborn's death, DCFS opened a child protection investigation against the newborn's mother. Two months later, DCFS indicated the mother for environmental neglect (#82), but unfounded her for inadequate shelter (#77) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Before the child protection investigation closed, DCFS opened an intact family services case for the family, which remained open at the time of the newborn's birth and death. The intact worker last met with the family at home the day before the newborn's death.

Child No. 103	DOB: 03/2024	DOD: 07/2024	Natural
Age at death:	3 months		
Cause of death:	Enterovirus infection		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Open intact family services case at time of child's death; unfounded child protection investigation and closed placement case within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Ten months before the infant's death, the infant's parents surrendered parental rights to the infant's older sibling, who was a youth in care and the sibling was adopted. Two days after the infant's birth, DCFS opened a child protection investigation against the infant's mother and father. Two weeks later, DCFS opened an intact family services case and unfounded the child protection investigation against the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The intact family services case remained open at the time of the infant's death. The intact worker last had contact with the family five days before the infant's death, during a home visit.

Child No. 104	DOB: 09/2019	DOD: 07/2024	Natural
Age at death:	4 years		
Cause of death:	Acute dehydration due to recent viral illness		
DCFS investigation:	Mother unfounded for death by neglect (#51)		
Reason for review:	Pending child protection investigation at time of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: At the time of the child's death, there was a pending child protection investigation against the child's mother that had been open for one month. DCFS later unfounded the mother for medical neglect (#79). The CPS last had contact with the family prior to the child's death one month before the death, when the CPS visited the home.

Child No. 105	DOB: 06/2024	DOD: 07/2024	Natural
Age at death:	3 weeks		
Cause of death:	Sudden unexpected infant death		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Approximately two months before the newborn's death, DCFS opened a child protection investigation against the newborn's mother. Three weeks later, DCFS unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). The CPS last had contact with the family two weeks before the investigation closed, when the CPS met with the newborn's father.

Child No. 106	DOB: 07/2024	DOD: 07/2024	Natural
Age at death:	8 days		
Cause of death:	Extreme prematurity due to respiratory failure due to necrotizing enterocolitis due to grade IV IVH; significant contributing factors of septic shock, hypotension, pulmonary hypertension, cerebellar hemorrhage, and total parenteral nutrition dependent		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Closed intact family services case within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: The newborn's family had an intact family services case that closed successfully six months before the newborn's birth and death, after it had been open for seven months. The intact worker last met with the family at the agency office one week before the case closed.

Child No. 107	DOB: 01/2017	DOD: 07/2024	Natural
Age at death:	7 years		
Cause of death:	Status asthmaticus		
DCFS investigation:	Father's paramour unfounded for death by neglect (#51)		
Reason for review:	Child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eleven months before the child's death, DCFS opened a child welfare services referral for the family. One month later, the referral closed. The CWS worker attempted to make contact with the family but was unsuccessful.

Child No. 108	DOB: 07/2024	DOD: 07/2024	Natural
Age at death:	10 days		
Cause of death:	Cardiorespiratory failure due to osteogenesis imperfecta type 2 due to osteogenesis imperfecta and prematurity		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Open placement case and pending child protection investigation at time of child's death; indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: One year before the newborn's birth, DCFS opened a child protection investigation against the newborn's parents and took protective custody of the newborn's sibling upon her birth. Ten months before the newborn's birth, DCFS indicated the mother for substance misuse by neglect (#65) and indicated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The newborn's sister remained in care. Several days after the newborn's birth, DCFS opened a child protection investigation against the newborn's parents. The newborn died in the hospital four days later, while the child protection investigation remained pending and the placement case for the sister remained open. The placement worker last saw the newborn's sister in her foster home the day before the newborn's death. DCFS later unfounded the newborn's mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 109	DOB: 04/2024	DOD: 07/2024	Natural
Age at death:	3 months		
Cause of death:	Myocardial infarction due to severe coronary artery stenosis		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child was a youth in care; one indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: The day of the infant's birth, DCFS opened a child protection investigation against the infant's mother. One week later, the infant came into DCFS care. Approximately two months before the infant's death, DCFS indicated the mother for substance misuse by neglect (#65) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The placement worker last had contact with the family the day of his death, during a visit to see the infant at the hospital with the family.

Child No. 110	DOB: 07/2019	DOD: 08/2024	Natural
Age at death:	5 years		
Cause of death:	Acute chronic aspiration pneumonia due to cerebral palsy and Lennox- Gastaut syndrome		
DCFS investigation:	Father unfounded for death by neglect (#51)		
Reason for review:	Child was a youth in care; one indicated and one unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Nine months before the child's death, DCFS opened an investigation against the child's mother. Two months later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). Five months before the child's death, DCFS opened another investigation against the child's mother. Two days later, the child and his sister came into care of DCFS and remained youth in care. Two months before the death, DCFS indicated the child protection investigation against the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), but unfounded her for medical neglect (#79). The children remained in care at the time of the child's death. The last contact occurred five days before the child's death, when a case aide supervised visitation between the mother and children.

Child No. 111	DOB: 05/2024	DOD: 08/2024	Natural
Age at death:	2 months		
Cause of death:	Interstitial pneumonia		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eleven months before the infant's death, DCFS opened a child welfare service referral for the family. Three weeks later, the referral closed. The CWS worker last had contact with the mother by phone a week after the referral opened.

Child No. 112	DOB: 06/2009	DOD: 08/2024	Natural
Age at death:	15 years		
Cause of death:	Cardiac arrest due to hypovolemic shock due to complication of surgery and anesthesia due to neuromuscular scoliosis; significant contributing factors of shunted hydrocephalis, history of intraventricular hemorrhage, spastic cerebral palsy, epilepsy, restrictive lung disease, medical frailty, chronic aspiration, gastrostomy tube dependence		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Four months before the teen's death, DCFS opened an investigation against the teen's mother and father. One month later, DCFS unfounded the mother and father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). The CPS last had contact with the parents by phone three days before the investigation closed.

Child No. 113	DOB: 10/2022	DOD: 08/2024	Natural
Age at death:	21 months		
Cause of death:	Complications of prematurity; significant contributing factors of panhypopituitarism and bronchopulmonary dysplasia		
DCFS investigation:	Mother and father unfounded for death by abuse (#51)		
Reason for review:	Child was a youth in care; closed intact family services case, three indicated child protection investigations and two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: In the three months before the toddler's death, DCFS opened five concurrent child protection investigations against the toddler's mother and father. DCFS unfounded the mother and father in the first investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). DCFS indicated the mother and father in the second investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). DCFS indicated the mother in the third investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) but unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). DCFS unfounded the mother and father in the fourth investigation for inadequate shelter (#77). During the investigations, DCFS opened an intact family services case. Less than two weeks later, DCFS opened a fifth child protection investigation against the toddler's mother and father. The following day, DCFS took protective custody of the toddler, and the intact family services case became a placement case. The day before the toddler's death, DCFS indicated the mother and father in the fifth child protection investigation for medical neglect (#79). At the time of the toddler's death, he remained a youth in care. The placement worker's last contact with the family prior to the toddler's death was a phone call with the mother the day before.

Child No. 114	DOB: 08/2024	DOD: 09/2024	Natural
Age at death:	3 weeks		
Cause of death:	Hypoxic respiratory failure due to obstructive lung disease		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Pending child protection investigation at time of child's death; closed intact family services case, unfounded child protection investigation, and closed child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Five months before the newborn's death, the family's intact family services case, which had been open for 16 months, closed successfully. Three weeks before the newborn's birth and over one month before his death, DCFS opened a child welfare services referral for the family. The referral closed two weeks later when DCFS opened a child protection investigation against the newborn's father. One week later, DCFS unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). One week before the newborn's death, DCFS opened a child protection investigation against the newborn's mother and father. The child protection investigation remained pending at the time of the newborn's death. DCFS later unfounded the mother, father, and a paramour for environmental neglect (#82). The family's last contact prior to the newborn's death occurred three days earlier, when the CPS met with the family in the community.

Child No. 115	DOB: 08/2015	DOD: 09/2024	Natural
Age at death:	9 years		
Cause of death:	Bronchial asthma; significant contributing factor of SARS-COV-2 (COVID-19) viral infection		
DCFS investigation:	Mother and father unfounded for death by neglect (#51)		
Reason for review:	Open intact family services case at time of child's death; unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Ten months before the child's death, DCFS opened a child protection investigation against the child's mother and father. One month later, while the investigation remained pending, DCFS opened an intact family services case. Two weeks later, DCFS unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and unfounded the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The intact family services case remained open at the time of the child's death. The intact worker last saw the family ten days before the child's death, during a home visit.

Child No. 116	DOB: 04/2019	DOD: 10/2024	Natural
Age at death:	5 years		
Cause of death:	Bronchial asthma		
DCFS investigation:	Mother and father unfounded for death by neglect (#51)		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: One year before the child's death, DCFS opened a child protection investigation against the child's mother and father. Three days later, DCFS unfounded the mother and father for inadequate supervision (#74) and medical neglect (#79). The CPS last saw the family at home the day after the investigation opened.

Child No. 117	DOB: 08/2008	DOD: 10/2024	Natural
Age at death:	16 years		
Cause of death:	Probable respiratory arrest, palliative DNR due to intractable seizure disorder, chronic lung disease, asthma, with tracheostomy due to malnutrition, cerebral palsy, microcephaly, hypotonia; significant contributing condition of underlying condition chronic worsened over time		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Over one year before the teen's death, DCFS opened a child protection investigation against the teen's mother. Eleven months before the death, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS last had contact with the family six days before the investigation closed, when the CPS visited the teen at the hospital while the teen was receiving treatment for an illness.

Child No. 118	DOB: 07/2015	DOD: 10/2024	Natural
Age at death:	9 years		
Cause of death:	Respiratory failure due to bilateral malignant pleural effusions due to advanced metastatic osteosarcoma		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Three months before the child's death, DCFS opened a child protection investigation against the child's mother. Two months before the child's death, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the child and his sibling. The CPS last had contact with the family one week before the investigation closed during a visit to the home.

Child No. 119	DOB: 04/2024	DOD: 10/2024	Natural
Age at death:	5 months		
Cause of death:	Extreme prematurity due to chronic lung disease due to sub glottic stenosis		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child was a youth in care; unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: The day after the infant's birth, DCFS opened an investigation against the infant's mother. The following day, the infant came into DCFS care on dependency. Approximately two months later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The infant remained a youth in care and never left the hospital following his birth. His placement worker last saw him approximately two weeks before his death, during a visit to the NICU.

Child No. 120	DOB: 02/2023	DOD: 10/2024	Natural
Age at death:	19 months		
Cause of death:	Enterovirus respiratory infection due to pulmonary hypertension due to trisomy 18		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Six months before the toddler's death, DCFS opened a child protection investigation against the child's mother. Two months later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). The CPS's last contact with the family was a home visit two weeks before the investigation closed.

Child No. 121	DOB: 02/2013	DOD: 10/2024	Natural
Age at death:	11 years		
Cause of death:	Cardiac arrest due to status asthmaticus		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Six weeks before the child's death, DCFS opened a child protection investigation against the child's father. Six days later, DCFS unfounded the father for environmental neglect (#82) to the child. The CPS's last contact with the family was a visit with the family at home, the day the investigation opened.

Child No. 122	DOB: 08/2024	DOD: 10/2024	Natural
Age at death:	8 weeks		
Cause of death:	Community acquired pneumonia		
DCFS investigation:	Mother unfounded for death by neglect (#51)		
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eight months before the infant's birth, and ten months before her death, DCFS opened a child protection investigation against the infant's mother and father. One month later, DCFS unfounded the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82). Two weeks before the infant's death, DCFS opened an investigation against the infant's mother and father. Two days before the infant's death, DCFS opened an intact family services case for the family. The intact family services case and child protection investigation remained open at the time of the infant's death. DCFS later unfounded the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82). The CPS and intact worker last met with the family the day before the infant's death, during a transitional visit to initiate the intact case.

Child No. 123	DOB: 05/2013	DOD: 12/2024	Natural
Age at death:	11 years		
Cause of death:	Cardiac arrhythmia congenital heart disease - complex due to chronic respiratory failure with hypoxemia due to trisomy 9 mosaic syndrome 9P deletion		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child was a youth in care		
OIG action taken:	Investigatory review of records		

Reason for review: DCFS received guardianship of the medically complex child at 3 years old, but she remained in the care of her mother. When she was 4 years old, the judge ordered the child to be placed in care. At the time of her death, she remained in care of DCFS, in a residential nursing facility. The placement worker last met with the child one month before her death, during a visit to the nursing facility.

Child No. 124	DOB: 03/2015	DOD: 12/2024	Natural
Age at death:	9 years		
Cause of death:	Pseudomonal sepsis due to pseudomonal UTI due to sequelae of TB meningitis		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Two months before the child's death, DCFS opened a child welfare services referral for the family, which closed one month later. The CWS worker last saw the family at home one week before the referral closed.

Child No. 125	DOB: 02/2022	DOD: 12/2024	Natural
Age at death:	2 years		
Cause of death:	Cardiac arrest due to cerebral palsy, tracheotomy, G-tube		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Open intact family services case at time of child's death; one indicated and four unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Nine months before the toddler's death, DCFS closed and unfounded two child protection investigations against the toddler's mother for medical neglect (#79). One investigation had opened five months earlier, and the second investigation opened one month earlier. Ten months before the toddler's death, while both child protection investigations remained pending, DCFS opened an intact family services case for the family. Eight months before the toddler's death, DCFS opened a child protection investigation against the toddler's father. Six weeks later, DCFS indicated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Two weeks after the previous investigation opened, DCFS opened a new child protection investigation against the toddler's mother. Six months before the toddler's death, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the toddler. Four weeks after the prior investigation opened, while it remained pending, DCFS opened another child protection investigation against the toddler's mother. Six months before the toddler's death, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and medical neglect (#79) to the toddler. The intact family services case remained open at the time of the toddler's death. The intact worker's last contact with the family occurred three days before the toddler's death, during a visit to the home.

Child No. 126	DOB: 11/2024	DOD: 12/2024	Natural
Age at death:	22 days		
Cause of death:	Malignant pertussis due to pulmonary hypertension due to acute respiratory distress syndrome		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: The day after the infant's birth, DCFS opened a child protection investigation against the newborn's mother. Ten days later, DCFS unfounded the mother for medical neglect (#79). The CPS's last contact with the family occurred the day after the hotline report, when the CPS met with the mother and newborn at home.

Child No. 127	DOB: 07/2024	DOD: 12/2024	Natural
Age at death:	5 months		
Cause of death:	Pneumonia		
DCFS investigation:	Mother and father unfounded for death by neglect (#51)		
Reason for review:	One unfounded child protection investigation		
OIG action taken:	Investigatory review of records		

Reason for review: One year before the infant's death, DCFS opened a child protection investigation against the infant's father and the mother of the infant's paternal half-siblings. Nine months before the infant's death, DCFS unfounded the father and half-siblings' mother for environmental neglect (#82) to their child, the infant's half-sibling. The family last had contact with the CPS's supervisor during a home visit with the half-siblings and their mother, and a phone call between the supervisor and the father the day before the child protection investigation closed.

Child No. 128	DOB: 10/2016	DOD: 12/2024	Natural
Age at death:	8 years		
Cause of death:	Hypertrophic cardiomyopathy; significant contributing conditions of cerebral palsy and myotonic muscular dystrophy		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child was a youth in care		
OIG action taken:	Investigatory review of records		

Reason for review: The child came into DCFS care four years earlier and remained in care until his death. The placement worker last met with the child one week before his death in the transitional medical facility where he resided.

Child No. 129	DOB: 09/2021	DOD: 01/2025	Natural
Age at death:	3 years		
Cause of death:	Acute on chronic respiratory failure, ARDS due to RSV and HMP pneumonia due to ARDS, sepsis syndrome		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Ten months prior to the toddler's death, DCFS closed a child protection investigation against an unknown perpetrator that had been open for two months. DCFS unfounded an unknown

perpetrator for bone fractures (#9) by abuse to the toddler. The CPS last had contact with the family two days before the investigation closed, during a meeting with a paternal aunt, who was a caregiver to the toddler.

Child No. 130	DOB: 08/2023	DOD: 01/2025	Natural
Age at death:	16 months		
Cause of death:	Bacterial sepsis, laryngotracheobronchitis, and hemorrhagic pneumonia		
DCFS investigation:	Mother and father unfounded for death by neglect (#51)		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eleven months before the toddler's death, DCFS opened a child protection investigation against the toddler's mother and father. Less than two weeks later, DCFS unfounded the mother and father for substantial risk of sexual abuse (#22) to the then 5-month-old toddler and her 7-year-old sister. Six months before the toddler's death, DCFS opened another child protection investigation against the toddler's mother and father. Two weeks later, DCFS unfounded the mother and father for environmental neglect (#82) to the toddler's 7-year-old sister. The CPS's last contact with the family occurred the day the investigation opened, when the CPS met with the family at home.

Child No. 131	DOB: 11/2012	DOD: 01/2025	Natural
Age at death:	12 years		
Cause of death:	Diffuse midline glioma		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Four months before the child's death, DCFS opened a child protection investigation against the child's mother. One month later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the child and her sister. The CPS last had contact with the family two days before the investigation closed, during a visit to the father's home.

Child No. 132	DOB: 06/2024	DOD: 01/2025	Natural
Age at death:	7 months		
Cause of death:	Cardiac arrest due to septic shock due to congenital heart disease		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Pending child protection investigation at time of child's death; one unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Four months before the infant's death, DCFS opened a child protection investigation against the infant's father. One month later, DCFS unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant and his siblings. One month before the infant's death, DCFS opened a new child protection investigation against a staff member at the school the infant's sibling attended. The investigation remained pending at the time of the infant's death. DCFS later unfounded the staff member for sexual molestation (#21) to the infant's sibling and flagged the report as harassment. The CPS's last contact with the family prior to the infant's death occurred two days after the investigation opened, when the CPS had a phone call with the infant's mother.

Child No. 133	DOB: 07/2019	DOD: 01/2025	Natural
Age at death:	5 years		
Cause of death:	Sepsis due to post transplant lymphoproliferative disorder due to heart transplantation		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child was a youth in care		
OIG action taken:	Investigatory review of records		

Reason for review: The medically complex child came into DCFS care when she was 22 months old and remained in care, in a specialized foster home, until her death. The placement worker's last contact with the family occurred six weeks before the child's death, during a child and family team meeting.

Child No. 134	DOB: 07/2022	DOD: 01/2025	Natural
Age at death:	2 years		
Cause of death:	Influenza and bacterial pneumonia; significant contributing factor of cerebral palsy		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Open intact family services case at time of child's death; one unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eleven months before the toddler's death, DCFS unfounded a child protection investigation against the toddler's mother for medical neglect (#79) and environment neglect (#82) to the toddler that had been open for two months. Twelve months before the toddler's death, while the investigation remained pending, DCFS opened an intact family services case for the mother, which remained open at the time of the toddler's death. The intact worker's last contact with the family prior to the toddler's death occurred four days earlier, when the intact worker transported the toddler and his mother to a medical appointment for the toddler.

Child No. 135	DOB: 08/2010	DOD: 02/2025	Natural
Age at death:	14 years		
Cause of death:	Traumatic brain injury from motor vehicle accident		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Pending child protection investigation at time of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Three months before the teen's death, DCFS opened a child protection investigation against the teen's mother and father. The investigation remained pending at the time of the teen's death. DCFS later unfounded the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the teen and his sister. The CPS's last contact with the family prior to the teen's death occurred five days after the investigation opened, when the CPS met with the family at home.

Child No. 136	DOB: 11/2015	DOD: 02/2025	Natural
Age at death:	9 years		
Cause of death:	Multiple complications of generalized lymphatic anomaly (GLA)		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Two child welfare services referrals within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Nine months before the child's death, DCFS opened a child welfare services referral for the family. The CWS worker contacted the family the following week, and DCFS closed the child welfare services referral three days later. Seven months before the child's death, DCFS opened a new child welfare services referral for the family. The CWS worker spoke with the father by phone one week later, and the father declined services. The child welfare services referral closed that day.

Child No. 137	DOB: 08/2023	DOD: 02/2025	Natural
Age at death:	17 months		
Cause of death:	Mitochondrial disease		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eight months before the toddler's death, DCFS opened a child protection investigation against the toddler's mother. Approximately two weeks later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler and her siblings. The CPS last had contact with the family two days after the investigation opened, during a visit to the home.

Child No. 138	DOB: 12/2024	DOD: 02/2025	Natural
Age at death:	2 months		
Cause of death:	Spinal muscular atrophy type zero		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Open placement case at time of child's death; one unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: At the time of the infant's birth, the infant's 17-year-old sister had been a youth in care for three years. Fourteen months before the infant's death, DCFS opened a child protection investigation against the sister's caregiver in her unauthorized placement. One month before the infant's birth, three months before his death, DCFS unfounded the sister's caregiver for inadequate supervision (#74) to the sister. The sister's placement case remained open at the time of the infant's death. The placement worker's last contact with the sister prior to the infant's death occurred four weeks earlier, when the placement worker conducted a routine visit at the sister's foster home. The infant never left the hospital after his birth.

Child No. 139	DOB: 05/2018	DOD: 02/2025	Natural
Age at death:	6 years		
Cause of death:	Cerebral herniation due to nontraumatic anoxic brain injury due to status epilepticus due to Dravet syndrome		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Three weeks before the child's death, DCFS opened a child protection investigation against the child's father. Two days before the child's death, DCFS unfounded the father for sexual exploitation (#20) to the child. The CPS's last contact with the family occurred two weeks after the investigation opened, when the CPS met with the father in person.

Child No. 140	DOB: 12/2020	DOD: 02/2025	Natural
Age at death:	4 years		
Cause of death:	Hydranencephaly; significant contributing factors of seizure disorder, chronic respiratory failure, failure to thrive		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Pending child protection investigation at time of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Six days before the medically complex child's death, DCFS opened a child protection investigation against the child's adoptive mother. The investigation remained pending when the child died at home, under hospice care. DCFS later unfounded the adoptive mother for inadequate supervision (#74) to the child's adoptive siblings and foster siblings. The CPS's last contact with the family prior to the child's death occurred the day after the investigation opened, during a visit to the home.

Child No. 141	DOB: 11/2023	DOD: 03/2025	Natural
Age at death:	15 months		
Cause of death:	Respiratory syncytial virus with bronchiolitis with pneumonia; significant contributing factors of COVID-19 and rhinovirus, upper respiratory tract infections, extreme prematurity with chronic anemia		
DCFS investigation:	Grandmother unfounded for death by neglect (#51)		
Reason for review:	Open intact family services case at time of child's death; one indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Four months before the toddler's death, DCFS opened a child protection investigation against the infant's mother and father. Approximately three weeks later, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and indicated both the mother and father for environmental neglect (#82) to the toddler and his sibling. Before the investigation closed, DCFS opened an intact family services case for the parents, which remained open at the time of the toddler's death. The intact worker's last contact with the family prior to the toddler's death occurred the day before the toddler's death, during a home visit with the children and their grandmother.

Child No. 142	DOB: 12/2011	DOD: 03/2025	Natural
Age at death:	13 years		
Cause of death:	Anoxic brain injury due to epilepsy; significant contributing factor of Angelman's syndrome		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Open intact family services case at time of child's death; one indicated and two unfounded child protection investigations, and one child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Seven months before the teen's death, DCFS opened a child welfare services referral for the family and provided resources to the family. Five months before the teen's death, DCFS opened a child protection investigation against the teen's mother. Two months later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and environmental neglect (#82) to the teen and his siblings. Four months before the teen's death, while the prior investigation was still pending, DCFS opened a separate child protection investigation against the mother. Five days later, DCFS unfounded the mother for inadequate supervision (#74) to the teen's sibling. Seven weeks before the teen's death, DCFS opened another child protection investigation against the teen's mother. Approximately one month later, DCFS opened an intact family services case and indicated the mother for environmental neglect (#82) to the teen and his siblings. The intact family services case remained open at the time of the teen's death. The intact worker last had contact with the family one week before the teen's death, during a visit to see the teen's siblings at a relative's home.

Child No. 143	DOB: 10/2010	DOD: 03/2025	Natural
Age at death:	14 years		
Cause of death:	Complications of Rett syndrome		
DCFS investigation:	Foster mother and foster mother's paramour unfounded for death by neglect (#51)		
Reason for review:	Child was a youth in care; unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: The child came into care of DCFS when he was 7 years old. Six months before the teen's death, DCFS opened a child protection investigation against the teen's relative foster mother. Three months later, DCFS unfounded the relative foster mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and inadequate supervision (#74). The teen remained in care at the time of his death. The family's last contact with DCFS prior to the teen's death occurred three days earlier, when the placement supervisor visited the foster home.

Child No. 144	DOB: 12/2015	DOD: 03/2025	Natural
Age at death:	9 years		
Cause of death:	Complications of probable intestinal motility disorder; significant contributing factors of cerebral palsy and multiple congenital central nervous system anomalies		
DCFS investigation:	Pending child protection investigation of death		
Reason for review:	Child was a youth in care		
OIG action taken:	Full investigation pending		

Reason for review: The child came into care when she was 6 years old, and she remained in care of DCFS at the time of her death. The placement worker last saw the child at her foster home six days before the child's death.

Child No. 145	DOB: 08/2011	DOD: 03/2025	Natural
Age at death:	13 years		
Cause of death:	Complications of organizing pneumonia due to neuromuscular scoliosis; contributing factors of spastic quadriplegic cerebral palsy and multiple congenital anomalies		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eleven months before the teen's death, DCFS opened a child protection investigation against the teen's mother. Five months later, DCFS unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the teen's sibling and inadequate supervision (#74) the teen and her siblings. The CPS last had contact with the family two weeks before the investigation closed, during a visit to see the teen's sibling at a relative's home.

Child No. 146	DOB: 08/2021	DOD: 03/2025	Natural
Age at death:	3 years		
Cause of death:	Cardiac arrest; significant contributing factors of hydrocephalus, meningitis requiring ureteropelvic shunt		
DCFS investigation:	No child protection investigation of death		
Reason for review:	One indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eight months before the toddler's death, DCFS opened a child protection investigation against his father. Two months later, DCFS indicated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPS's last contact with the family occurred two days before the investigation closed, when the CPS visited the family at home.

Child No. 147	DOB: 03/2014	DOD: 03/2025	Natural
Age at death:	11 years		
Cause of death:	Sepsis due to streptococcus pyogenes (group A strep) pneumonia		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Open intact family services case at time of child's death; four indicated child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: In the twelve months before the child's death, DCFS closed and indicated four separate child protection investigations against the child's mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the child and her siblings. The fourth investigation closed one month before the child's death. Two months before the child's death, before the third investigation closed, DCFS opened an intact family services case, which remained open at the time of the child's death. The intact worker's last contact with the family prior to the child's death occurred four days earlier, during a visit to the home.

Child No. 148	DOB: 04/2025	DOD: 04/2025	Natural
Age at death:	1 day		
Cause of death:	Cardiorespiratory failure due to extreme prematurity		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Closed Placement and one unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Nine months before the newborn's death, the placement case for the newborn's siblings closed after they returned to their father's care. The siblings had been in care of DCFS for two years. The placement worker's last contact with the family occurred during the family's court hearing the day the case closed. The same day the placement case closed, DCFS also unfounded a child protection investigation against the newborn's mother for environmental neglect (#82) to the newborn's sibling. The investigation had been open for four months.

Child No. 149	DOB: 12/2023	DOD: 04/2025	Natural
Age at death:	15 months		
Cause of death:	Liver sarcoma		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Open intact family services case at time of child's death; three unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Ten months before the toddler's death, DCFS opened a child protection investigation against the toddler's mother and father. Three months later, DCFS unfounded the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler. Before the investigation closed, DCFS opened an intact family services case for the family. Five months before the toddler's death, DCFS opened parallel investigations against the toddler's mother and father. Two months before the toddler's death, DCFS unfounded both investigations against the mother and the father for medical neglect (#79) to the toddler. The intact family services case remained open at the time of the toddler's death. The intact worker's last contact with the family before the toddler's death was a phone call with the father four days earlier.

Child No. 150	DOB: 11/2023	DOD: 04/2025	Natural
Age at death:	16 months		
Cause of death:	Absent right pulmonary artery due to pulmonary hypertension due to pulmonary hemorrhage		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eleven months before the toddler's death, DCFS opened a child protection investigation against the toddler's mother. One week later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler. The CPS last had contact with the family two days after the investigation opened, during a visit to the home.

Child No. 151	DOB: 08/2007	DOD: 04/2025	Natural
Age at death:	17 years		
Cause of death:	Ewing sarcoma with metastasis to the scalp and shoulder		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eleven months before the teen's death, DCFS opened a child protection investigation against the child's father. One month later, DCFS indicated the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the teen and his siblings. The CPS's last contact with the family occurred the day the investigation closed, when the CPS spoke with the father by phone.

Child No. 152	DOB: 08/2020	DOD: 04/2025	Natural
Age at death:	4 years		
Cause of death:	Acute hypoxemic respiratory failure due to pseudomonas pneumonia due to tetrahydrobiopterin deficiency		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Approximately six months before the child's death, DCFS opened a child welfare services referral for the family. Twelve days later, the referral closed with a link to community services. DCFS last had contact with the family the day the referral closed, when the CWS worker and mother exchanged text messages.

Child No. 153	DOB: 03/2023	DOD: 04/2025	Natural
Age at death:	2 years		
Cause of death:	Unexplained sudden death (intrinsic factors identified)		
DCFS investigation:	Mother unfounded for death by neglect (#51)		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Seven months before the toddler's death, DCFS opened a child protection investigation against the toddler's mother and her paramour. Approximately two months later, DCFS unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the toddler's brother.

DCFS also unfounded the mother's paramour for sexual molestation (#21) to the toddler's sister and substantial risk of sexual abuse (#22) to the toddler's brother. Two days after the investigation closed, DCFS opened another investigation against the toddler's mother and her paramour. Three weeks later, DCFS unfounded the paramour for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the toddler's siblings and unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler and her siblings. The CPS's last contact with the family occurred four days after the investigation opened, when the CPS conducted a home visit.

Child No. 154	DOB: 08/2015	DOD: 04/2025	Natural
Age at death:	9 years		
Cause of death:	Pulmonary hemorrhage due to disseminated intravascular coagulopathy due to pseudomonal sepsis in leukemia patient		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Open intact family services case at time of child's death; one unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Ten months before the child's death, DCFS opened a child protection investigation against the child's father. One month later, DCFS unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), inadequate shelter (#77), and medical neglect (#79) to the child and his sibling. Before the investigation closed, DCFS opened an intact family services case for the family, which remained open at the time of the child's death. The intact worker's last contact with the family prior to the child's death occurred nine days earlier, during a visit to the home.

Child No. 155	DOB: 01/2025	DOD: 04/2025	Natural
Age at death:	3 months		
Cause of death:	Sudden unexpected infant death		
DCFS investigation:	Mother and father unfounded for death by neglect (#51)		
Reason for review:	Open intact family services case at time of child's death; one indicated child protection investigation and one child welfare services referral within one year of child's death		
OIG action taken:	Included in pending systemic issue report		

Reason for review: Three days after the infant's birth, DCFS opened a child welfare services referral for the family. Four days later, the referral closed after DCFS opened a child protection investigation against the infant's mother and father. One month later, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant but unfounded the father for the same allegation. While the child protection investigation remained pending, DCFS opened an intact family services case for the family. The intact case remained open at the time of the infant's death. The intact worker's last contact with the family prior to the infant's death occurred six days earlier, during a visit to the home.

Child No. 156	DOB: 02/2025	DOD: 05/2025	Natural
Age at death:	2 months		
Cause of death:	Cardio respiratory failure due to multi organ failure due to Smith Lemli-Opitz syndrome		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Open intact family services case at time of child's death; one indicated and one unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Six months before the medically complex infant's death, DCFS opened a child protection investigation against the child's maternal grandmother. Four months before the infant's death, DCFS unfounded the grandmother for inadequate shelter (#77) to the infant's mother. Three months before the infant's death, DCFS opened a child protection investigation against the infant's grandmother and grandfather. The infant was born during the investigation and remained hospitalized until her death. One week after the infant's birth, DCFS indicated the infant's maternal grandmother and maternal grandfather for medical neglect (#79) to the infant's mother, but unfounded the grandmother and grandfather for sexual penetration (#19) to the mother. DCFS opened an intact family services case when the child protection investigation closed. The intact case remained open at the time of the infant's death. The intact worker's last contact with the family prior to the infant's death occurred one week earlier, when the intact worker visited the hospital.

Child No. 157	DOB: 10/2023	DOD: 05/2025	Natural
Age at death:	19 months		
Cause of death:	Hypoxic ischemic encephalopathy		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Three months before the toddler's death, DCFS opened a child welfare services referral for the family. The referral closed eleven days later with no services needed. The CWS worker's last contact with the family occurred four days before the referral closed, when the mother text messaged the CWS worker.

Child No. 158	DOB: 08/2021	DOD: 05/2025	Natural
Age at death:	3 years		
Cause of death:	Pneumonia due to central apnea non-traumatic		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child was a youth in care		
OIG action taken:	Investigatory review of records		

Reason for review: The medically complex toddler came into DCFS care when she was 6 months old on a no-fault dependency and remained in a long-term care facility until her death. The placement worker last visited the toddler three weeks before her death.

Child No. 159	DOB: 04/2024	DOD: 05/2025	Natural
Age at death:	13 months		
Cause of death:	HSV encephalopathy		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Five months before the toddler's death, DCFS opened a child protection investigation against the toddler's father. Two months later, DCFS indicated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler. The CPS last saw the family three days before the investigation closed, during a visit to the home.

Child No. 160	DOB: 11/2015	DOD: 05/2025	Natural
Age at death:	9 years		
Cause of death:	Malignant neoplasm of the cerebellum with metastasis to the spine due to medulloblastoma		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Nine months before the child's death, DCFS opened a child protection investigation against the child's mother. Two months later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and inadequate supervision (#74) to the child. Six months before the child's death, DCFS opened another child protection investigation against the child's mother. Approximately three weeks later, DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and inadequate food (#76) to the child. The CPS last had contact with the family one week before the investigation closed, during a visit to the home.

Child No. 161	DOB: 09/2023	DOD: 06/2025	Natural
Age at death:	20 months		
Cause of death:	Metastatic malignant rhabdoid tumor		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Indicated child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Eleven months before the toddler's death, DCFS initiated a child protection investigation against the toddler's mother. Two months later, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler. The CPS's last contact with the family occurred during a home visit two weeks before the investigation closed.

Child No. 162	DOB: 07/2024	DOD: 06/2025	Natural
Age at death:	11 months		
Cause of death:	Complications of cerebral palsy		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Child welfare services referral within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Four months before the infant's death, DCFS opened a child welfare services referral for the family. The referral closed one month later, after the family denied they needed additional services. The CWS worker's last contact with the family occurred one week after the referral opened, during a visit to the home.

Child No. 163	DOB: 07/2023	DOD: 06/2025	Natural
Age at death:	23 months		
Cause of death:	Septic shock due to immunosuppression due to S/P bone marrow transplant due to neuroblastoma abdominal; significant contributing conditions of acute hypoxic respiratory failure, hypovolemic shock, pancytopenia, pneumatosis intestinalis, pancreatitis, typhlitis		
DCFS investigation:	No child protection investigation of death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
OIG action taken:	Investigatory review of records		

Reason for review: Two months before the toddler's death, DCFS opened a child protection investigation against the toddler's father. Two weeks before the toddler's death, DCFS unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). The CPS last met with the family at home four days before the investigation closed.

TWENTY-YEAR DEATH RETROSPECTIVE

FISCAL YEAR	2006-20 AVG	2006-20 %	2021 #	2021 %	2022 #	2022 %	2023 #	2023 %	2024 #	2024 %	2025 #	2025 %	2006-25 TOTAL	2006-25 AVG	2006-25 %
CASE STATUS	AVG	%	#	%	#	%	#	%	#	%	#	%	#	#	%
Youth in Care	20	20%	11	9%	26	15%	30	19%	31	18%	22	13%	**418**	**21**	**18%**
Unfounded DCP	28	28%	45	37%	53	31%	55	34%	53	32%	56	34%	**677**	**34**	**30%**
Pending DCP	15	15%	20	16%	34	20%	23	14%	25	15%	23	14%	**350**	**18**	**15%**
Indicated DCP	8	8%	14	11%	11	6%	14	9%	16	10%	9	6%	**189**	**9**	**8%**
Child of Youth in Care	2	2%	0	0%	1	1%	1	1%	1	1%	1	1%	**34**	**2**	**1%**
Open Intact	12	12%	14	11%	23	13%	19	12%	18	11%	20	12%	**274**	**14**	**12%**
Closed Intact	4	4%	6	5%	8	5%	8	5%	7	4%	5	3%	**99**	**5**	**4%**
Open Placement/ Split Custody	5	5%	9	7%	6	4%	6	4%	9	5%	3	2%	**102**	**5**	**4%**
Closed Placement/ Return Home	1	1%	3	2%	3	2%	0	0%	1	1%	3	2%	**32**	**2**	**1%**
Others	5	5%	0	0%	6	4%	4	3%	7	4%	21	13%	**115**	**6**	**5%**
TOTAL	100	100%	122	100%	171	100%	160	100%	168	100%	163	100%	2290	110	100%

FISCAL YEAR	AVG 06-19	20	21	22	23	24	25	Total 06-25
Total Deaths	**100**	**102**	**122**	**171**	**160**	**168**	**163**	**2290**
Youth in Care	**20**	**21**	**11**	**26**	**30**	**31**	**22**	**418**
Natural	9	7	5	9	11	15	10	183
Accident	3	4	2	3	10	8	5	78
Homicide	5	4	2	10	7	3	3	99
Suicide	1	3	1	1	1	1	2	24
Undetermined	1	3	1	3	1	4	2	34
Unfounded Investigation	**28**	**29**	**45**	**53**	**55**	**53**	**56**	**677**
Natural	7	11	21	23	23	15	19	210
Accident	10	13	8	11	15	11	16	213
Homicide	5	1	6	12	15	16	8	127
Suicide	1	1	3	3	1	4	3	33
Undetermined	4	3	7	4	1	7	10	94
Pending Investigation	**15**	**11**	**20**	**34**	**23**	**25**	**23**	**350**
Natural	4	7	7	12	8	8	5	106
Accident	4	3	7	9	4	7	3	93
Homicide	3	1	3	7	6	3	6	62
Suicide	1	0	0	1	1	4	0	13
Undetermined	4	0	3	5	4	3	9	76
Indicated Investigation	**8**	**14**	**14**	**11**	**14**	**16**	**9**	**189**
Natural	2	6	4	4	5	6	4	60
Accident	3	3	4	2	2	6	3	55
Homicide	1	2	2	4	2	2	1	33
Suicide	0	1	2	0	0	0	0	7
Undetermined	2	2	2	1	5	2	1	34
Child of a Youth in Care	**2**	**1**	**0**	**1**	**1**	**1**	**1**	**34**
Natural	1	0	0	0	0	0	0	12
Accident	0	1	0	1	0	0	0	6
Homicide	0	0	0	0	0	0	0	4
Suicide	0	0	0	0	0	0	0	0
Undetermined	1	0	0	0	1	1	1	12
Open Intact	**12**	**13**	**14**	**23**	**19**	**18**	**20**	**274**
Natural	5	4	5	11	9	9	13	114
Accident	3	5	3	5	3	4	3	66
Homicide	2	2	3	4	3	2	1	42
Suicide	0	0	0	0	0	0	1	4
Undetermined	2	2	3	3	4	3	2	48

FISCAL YEAR	AVG 06-19	20	21	22	23	24	25	Total 06-25
Closed Intact	**4**	**5**	**6**	**8**	**8**	**7**	**5**	**99**
Natural	2	4	2	2	4	1	1	35
Accident	1	0	2	3	0	0	2	24
Homicide	1	0	0	1	1	1	0	13
Suicide	0	0	0	1	0	1	0	2
Undetermined	1	1	2	1	3	4	2	25
Open Placement/Split Custody	**5**	**2**	**9**	**6**	**6**	**9**	**3**	**102**
Natural	3	1	4	2	2	3	2	52
Accident	1	0	0	3	1	4	1	23
Homicide	1	0	1	1	2	0	0	11
Suicide	0	0	1	0	1	0	0	2
Undetermined	1	1	3	0	0	2	0	14
Adopted	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Former Youth in Care	**1**	**0**	**0**	**4**	**1**	**1**	**1**	**22**
Closed Placement/ Return Home	**2**	**1**	**3**	**3**	**0**	**1**	**3**	**32**
Interstate Compact	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Preventive Services	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**16**
Subsidized Guardianship	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Child of Former Youth in Care	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**3**
Extended Family Support	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**10**
Child Welfare Referral	**2**	**3**	**0**	**2**	**3**	**6**	**20**	**63**

PART III: GENERAL INVESTIGATIONS

General Investigation 1

COMPLAINT A child protection specialist was alleged to have worked full time, during the same hours, for both a Child Welfare Contributing Agency (CWCA) and the Department (DCFS).

INVESTIGATION IG investigators found that the employee was being paid for full time employment as both a child protection specialist for DCFS and as a placement worker for a child welfare agency for six months. The employee was already employed at the child welfare agency when she was hired with DCFS. The employee told IG investigators that she only worked part-time at the child welfare agency, after DCFS hours and on weekends, to complete home visits for Spanish speaking families as the agency was short staffed on Spanish speaking workers. The employee's attendance and payroll records reflected full-time employment and salary for both DCFS and the child welfare agency.

Two months into the employee's dual employment, she sent an inquiry via email to the Conflict-of-Interest Committee to determine if her employment was a conflict. Nine days later the committee responded, informing the employee that the dual employment would be a conflict and cited multiple applicable policies, such as DCFS Rule 437.40 (b), which prohibits dual employment with DCFS and a contracted child welfare agency. The employee responded that she would submit her resignation to the child welfare agency as soon as possible, however, the employee remained dually employed for an additional four months.

The employee told IG investigators that she attempted to resign from the child welfare agency, however, her supervisor threatened to take retaliatory action, a claim which was not substantiated by the OIG. The employee further stated that she told her supervisor to only pay her for the part-time hours she worked. Over the six-month period, the supervisor approved the employee's full time pay and timecards, telling IG investigators that her approvals were an oversight. The supervisor denied that the employee requested to be paid for part-time hours.

Due to the employee's travel logs for the contracted child welfare agency only reflecting the date of visits and not the time, IG investigators were unable to determine if these visits occurred during her DCFS scheduled hours. However, the employee sent emails from her child welfare agency email during DCFS work hours.

IG investigators also found that when the employee made client visits for the contracted child welfare agency, she emailed notes of her visits to her supervisor who would then enter the contact notes in the case management system as though the supervisor had made the visit. None of the notes reflected that the employee made the visits. The supervisor confirmed that she had not made the visits and indicated that writing the notes that way was an oversight. The supervisor was later terminated for signing off on fraudulent timesheets.

RECOMMENDATIONS **1. The Child Protection Specialist should be discharged for wrongfully maintaining concurrent employment with DCFS and a child welfare contributing agency; for misuse of state time; failure to adhere to the determination of the Conflict-of-Interest Committee regarding her secondary employment; and for conduct unbecoming when she provided false information to the Department.**

The employee resigned from the Department.

2. The OIG will share the report with the new CWCA agency where the supervisor is now employed for review of her conduct while employed at her prior CWCA agency.

The Inspector General shared the report and met with CWCA leadership. The supervisor was discharged from the CWCA. In response to the report, the CWCA strengthened the reference check process and revised application questions.

3. The OIG will share the report with the Agency Performance Monitoring and Execution (APME) team assigned to both the supervisor's prior and current CWCA agencies.

The report was shared with APME.

General Investigation 2

COMPLAINT A Department employee used her privileges as a timekeeper to access the time-keeping system and award herself unearned overtime pay of at least $22,000.

INVESTIGATION IG investigators found that in an 11-month period, the employee altered timekeeping entries for 152 dates. The altered entries included 908.9 hours of unapproved overtime. The altered entries also included 165 hours of benefit time the employee credited back to herself when she altered days on which she was approved to use paid time off to instead show that she worked on those days. These alterations almost always occurred on the timekeeping deadline date, after another timekeeper assigned to enter the employee's time had entered the employee's time.

During the OIG investigation, the Department changed the timekeeping processes to remove access for all DCFS timekeepers from their own timekeeping record. OIG referred the investigation to the Illinois State Police.

RECOMMENDATIONS **1. The Department should discipline the employee, up to and including discharge.**

The employee resigned from the Department with no reinstatement rights.

General Investigation 3

COMPLAINT A Child Welfare Contributing Agency (CWCA) life skills worker allegedly stole money from a youth-in-care's community bank account.

INVESTIGATION The CWCA's Transitional Living Program (TLP) and Independent Living Opportunity (ILO) assigned a life skills worker to educate and assist a developmentally delayed youth-in-care with financial fluency for the purpose of preparing for independence.

Inspector General investigators found that the CWCA life skills worker was given independent latitude with the youth's finances including assisting the youth in obtaining a community bank account. This encompassed the life skills worker being placed on the youth's account as co-signer, the agency's standard practice at the time so that the youth's finances could be monitored. As a result, the life skills worker had full access to the youth's bank account.

In a one-year period, the life skills worker transferred $2,998.00 from the youth's savings account into two different personal bank accounts owned by the life skills worker, leaving the youth with just $1.00 in savings. The life skills worker also coaxed the youth into endorsing his paychecks over to the life skills

worker telling the youth that he would place the money in the youth's savings account, which he never did. In total, the life skills worker stole $24,406.75 from the youth.

The life skills worker's actions were discovered after the CWCA Chief Financial Officer reviewed the agency's food budget where it was found that the worker made unauthorized purchases at a local grocery store, charging it to the CWCA. The life skills worker was subsequently terminated, the criminal matter was referred to local police, and the CWCA provided the youth with full restitution of the money unlawfully taken.

IG investigators conducted a systemic investigation and found that prior to discovering the theft, neither the CWCA Finance Department, the youth's case worker, nor the Family Service Coordinator were aware the youth had a community bank account. The CWCA Finance Department was also never informed that the youth had a job in the community which necessitated the need for a community bank account.

Department procedures require a youth in care, who is enrolled in a Transitional Living Program (TLP) or an Independent Living Opportunity (ILO), and working, to have a community bank account. The OIG found, however, that the Department's procedures for establishing and monitoring a youth's community bank account were deficient.

In addition to control of the youth's community bank account, IG investigators found that the life skills worker independently completed the youth's monthly budget and received the bank statements. The life skills worker was responsible for reporting the youth's current balances during staffings, to which he misreported and falsified agency progress notes indicating that the youth was uncooperative in allowing the life skills worker to monitor the youth's finances. The life skills worker was responsible for placing monthly bank statements in the youth's file however he only filed two statements, both that were falsified. IG investigators found that during this time, none of the life skills worker's statements about the youth financial progress were verified.

Following a law enforcement investigation, the life skills worker plead guilty to theft and was sentenced to 30 months' probation, ordered to pay assessment and restitution in the amount of $24,406.57, and ordered to serve 74 days of periodic imprisonment and 14 days of home confinement.

RECOMMENDATIONS

1. The Department should provide guidance to CWCA staff regarding the logistics and monitoring of bank accounts for youth in care placed in ILO/TLP programs. The guidance should also address the dilemma faced when a youth in care under the age of 18 needs a co-signer to open a bank account. The guidance should be incorporated in procedures and ILO/TLP program plans.

Caseworkers should not open bank accounts for youth in care. The caseworker and the youth are required to contact the Economic Awareness Council hotline at 773-955-9000 to help youth in care open bank accounts without a parent or guardian. Each young adult must complete the CFS 370-5Y, Monthly Budget Form for Young adults, which shall be reviewed monthly for irregularities. The Department's division of Monitoring has led the effort to develop and implement guidance to be incorporated in ILO/TLP program plans. Additionally, a comprehensive review of the Department's approach to financial literacy and the CFS 370-5Y has been completed to facilitate the revision of the document and institute financial safeguards for youth in care. In June 2025, the Director highlighted this case at the full Child Welfare Advisory Committee meeting and discussed the issue and safeguards that were being put into place.

2. The Department should revise the CFS 370-5Y, *Monthly Budget for Youth* **form to include a line item that reflects the youth in care's current bank account balance. In addition, Procedures 301.60(e)(7)(B) Financial Self-Sufficiency, should require that the caseworker review the youth's bank statement with the youth in care while completing the CFS 370-5Y for both educational purposes and to check**

for irregularities. The bank statements should be attached to the monthly budgeting form and be placed in the file.

Each young adult must complete the CFS 370-5Y, Monthly Budget Form for Young adults, which shall be reviewed monthly for irregularities. The Department's division of Monitoring has led the effort to develop and implement guidance to be incorporated in ILO/TLP program plans. Additionally, a comprehensive review of the Department's approach to financial literacy and the CFS 370-5Y has been completed to facilitate the revision of the document and institute financial safeguards for youth in care.

3. The OIG will share the report with the CWCA. The CWCA should further revise their banking policy to ensure staff are not on the youth in care's community bank account. The CWCA should address the issue of youth endorsing their paychecks to a worker. In addition, as part of ongoing financial literacy, the CWCA should educate youth in care on the dangers of endorsing checks to other people.

The Inspector General shared the report and met with CWCA leadership. In response to the OIG's report the CWCA revised their banking process to include increased oversight by the CWCA's Finance Department and clearer guidance to staff. The CWCA will also require youth in care to complete a financial literacy course prior to opening a community bank account. In addition, the risks of endorsing checks will be explained in the Preparation for Adult Living Group attended by youth in care.

General Investigation 4

COMPLAINT A former Child Welfare Contributing Agency (CWCA) intact family services worker was alleged to have misappropriated client's Norman Cash Assistance funds.

INVESTIGATION Norman Cash Assistance funds are intended to provide short term financial assistance to clients for essential items such as food, shelter, clothing or beds. The OIG investigation found that the worker requested Norman Cash Assistance funds on behalf of five clients, obtained the physical check for the requested items, and presented the check to the retailer where it was then converted into gift cards or cash. The OIG investigation found that the gift cards and cash were used to provide the families with minimal items valued at a fraction of the original assistance amount, while the worker used the remaining funds for her own personal use.

The OIG conducted a systemic review of current DCFS procedure and policy regarding the use of Norman Cash Assistance. IG investigators found that Department procedure, guidance and training did not adequately address the expectations of the family and worker for purchases at retail stores. Despite there being a rigorous approval process for receiving Norman funds, there was little to no expectation of reconciliation of receipts for the approved items purchased and no expectation of assurance that the client received the items. Though Department procedures indicate that families should be notified by DCFS of their Norman Cash Assistance approval, IG investigators found this was not practiced. IG investigators found that the Department relied heavily on the integrity of the worker to share with the families that funds were requested on their behalf or the status of the funds request. IG investigators found that as a result, clients were unaware of the items they were approved for and did not know to inform anyone if they did not get the approved items. IG investigators found that the expectation on the use of funds to shop with the client was not adequately addressed in Department procedures.

IG investigators found that after the CWCA learned of the misuse of the funds, the worker resigned from the CWCA and was subsequently hired by the Department as a child protection specialist without Department knowledge of the misappropriation of the client funds. The Department terminated the worker's employment during the OIG investigation.

RECOMMENDATIONS **1. The Department should revise current procedures to increase oversight of Norman Funds issued for clients. Procedures should include a reconciliation process and notification of approval or denial of Norman Funds to the family from the Department's Office of Housing and Cash Assistance. The notification of approval should include expectations for the use of the funds and notification of denial should include the appeal process.**

The Department has begun the process of revising the procedures for Norman funds, as well as future state mapping for requesting and delivering cash assistance in IllinoisConnect. The Department plans to integrate automated notification of approval/denial of Norman Funds to the family into the new system, and that notification will also include information about the appeal process. The Department's Office of Housing and Cash Assistance has an existing process for ensuring funds are requested in accordance with procedure. Reconciliation occurs at quarterly and annual monitoring visits. Increasing the oversight of the cash assistance process using our current case management and financial systems would create significant cost burden on both the Department and the contracted cash assistance providers, much greater than any possible recoupment.

2. The Department should explore the feasibility of utilizing Norman Funds for online purchases for families and develop guidelines for the field.

The Department's Office of Housing and Cash Assistance has begun utilizing a protocol that enables checks to be made payable to Child Welfare Contributing Agencies (CWCA), so they can use their resources to make online purchases after receiving the approval from the Department. The Department is also open to exploring the feasibility of utilizing Norman Funds for online purchases once the cash assistance program is enabled in IllinoisConnect.

3. The intact worker should not be rehired by DCFS or any other State Agency. A do not rehire directive should be entered into the Central Management Services' personnel database.

The former intact worker does not have reinstatement rights to return and a notation was entered in the CMS database that the employee should not be rehired.

4. A redacted copy of the report should be placed in the intact worker's personnel file.

A redacted copy of the report was placed in the personnel file.

General Investigation 5

COMPLAINT A Department child welfare specialist (CWS) allegedly engaged in a personal relationship with a father on a placement case she was assigned. The allegations included that the caseworker received monetary payments from the father and was pregnant with the father's baby. The CWS resigned from the Department at commencement of the OIG investigation.

INVESTIGATION The family first came to the Department's attention following a hotline report alleging the father abused the mother in the presence of their 2-year-old twins. The investigation unfounded the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the children.

Four years later, the mother was unfounded for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and inadequate food (#76) to her children after a report to the hotline that the mother improperly fed her 6-day-old newborn and hit her 6-year-old twins. During the investigation, doctors noted they had no concerns for the health of the newborn nor was there evidence the mother abused the twins.

One year after the previous investigation, a teacher called the hotline stating one of the 7-year-old twins had a mark on his side and the child said it was caused by his mother hitting him with a belt. During the child protection investigation, the other twin corroborated his brother's story and added that there was domestic violence in the home. The mother and father denied the child was hit with a belt, stating that the injury occurred at a park. The mother stated the father abused her and was an alcoholic. The Department took protective custody of the then 7-year-old twin boys and 1-year-old girl due to domestic violence, substance abuse, and physical abuse. The twins and their sister were placed with their paternal step-grandmother. The mother was indicated for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The Department opened a placement case and provided the family with services.

IG investigators found that in the first five months of the placement case, the mother cooperated with the placement agency and completed all recommended services. During that time, the father was not compliant with services and visited infrequently. Unsupervised visits for the mother were granted and the placement supervisor noted if visits continued to go well, the Department would recommend return home to the mother. One month later, the placement case was reassigned to a new CWS, the subject of the OIG investigation. Later that month, the mother gave birth to a girl who remained with the mother.

IG investigators found that for the first two months after the new CWS was assigned the placement case, progress continued towards return home to the mother. However, after a couple of months, the CWS began to document negative progress and interactions from the mother and positive interactions and progress from the father. At a dispositional court hearing, the CWS testified to the mother's lack of compliance. IG investigators found no evidence that the mother was non-compliant or hindered the compilation of critical case information. The CWS also testified that she did not believe the mother's reports of domestic violence with the father, but one week after the dispositional hearing, the CWS completed a DCFS Clinical Referral Form in which the CWS documented the mother had a long history of domestic violence with the father including leaving the father on multiple occasions. IG investigators found that the CWS made repeated false claims about the father's progress with services to various DCFS and court related personnel.

During the OIG interview, the CWS told IG investigators that her romantic relationship with the father began six months after the case was assigned to her and that he was the father of her baby. Phone records revealed a 91% increase in communications between the CWS and the father as early as four months after case assignment. IG investigators found that the CWS began using her personal cell phone to communicate with the father and each month thereafter there was a significant increase in phone contacts. In addition, IG investigators found that over a five-month period, on five different occasions, the father sent the CWS Cash App payments totaling $920.00.

Around the time there was significant increase in communication with the father on her personal cell phone, the CWS changed the return home goal from the mother to the father, with approval from the supervisor. The mother had completed all recommended services while the father had not completed any services. The supervisor told IG investigators that she changed her opinion on the case based on the CWS's negative report about the mother and positive report about the father. Ultimately, the court returned the now 8-year-old twins and 2-year-old toddler to the father and six months later, the placement case closed.

The same month that the permanency goal was changed, the CWS called the hotline reporting concerns for the mother's care of the infant. During the investigation, the child protection supervisor (CPS) spoke with the mother's providers who confirmed her completion of services. The CPS also spoke with the mother's therapist, who reported the mother had made substantial progress. Neither the CWS nor her supervisor could provide specific evidence to the CPS of how the mother was abusing or neglecting the infant. Eight days after the investigation opened, the mother was unfounded for substantial risk of

physical injury/environment injurious to health and welfare by neglect (#60) to the infant by the mother. The investigation was marked for harassment.

One month after the previous investigation closed, the CWS again called the hotline reporting concerns about the mother's mental health and her care of her infant. During the investigation, the CPS interviewed several people associated with the placement case including the mother's babysitter, the CWS, and the CWS supervisor; none of those interviewed could provide specific examples of the reported concerns for the mother's mental health. At the same time, the mother completed a Psychological and Parenting Capacity Evaluation which noted the mother was an appropriate parent, the mother had bonded with her child, and the mother provided written documentation of completed services. The mother was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant.

RECOMMENDATIONS

1. Given the concerning rise of credible referrals for OIG investigations involving inappropriate relationships between Department or CWCA employees and their clients, the Department should provide ongoing guidance to the field regarding inappropriate personal relationships with clients as outlined in the Code of Ethics for Child Welfare Professionals. The guidance to the field should include the consequences of violating the Code of Ethics which may include loss of employment and Child Welfare Employee Licensure action.

The Department has taken numerous steps to address this very serious issue. The Office of Employee Services has added this topic to an onboarding manual for new hires and it has been added to the Foundations Training curriculum. The topic has been discussed at leadership meetings, and executive leadership is to engage and have conversations with staff at all levels of the Department regarding appropriate boundaries with clients. Once the online module is completed for new hires, it will also be added as a refresher for current staff.

2. When a psychological evaluation is conducted for a DCFS involved client, the Department should ensure the psychologist interviews the current therapist, when applicable and with required consents, to provide a more comprehensive evaluation.

The DCFS Psychology & Psychiatry Program has Guidelines that are forwarded to all providers. The Guidelines state, "If not already reported in the previous records section, this section should begin with a few sentences that contain the following demographic information of the client: name, age, gender, marital status, ethnicity, and occupation, as well as child's current placement. The section should summarize pertinent interview information obtained from collateral sources, including parents, therapists, teachers, GALs, etc.) The following areas should be covered: vocational, academic, medical, psychiatric, substance abuse, criminal and legal history, and history of DCFS involvement."

3. The CWS resigned at the commencement of the OIG investigation. A Do Not Rehire designation should be placed in the CWS's personnel file and entered in the Central Management Services' personnel database.

A notation was entered in the CMS database that the employee should not be rehired.

General Investigation 6

COMPLAINT A child protection advanced specialist (CPAS) allegedly failed to see the 6-year-old and 6-month siblings of a two-year-old who sustained life threatening injuries following a car accident in which the mother was intoxicated, and the toddler was not properly restrained. The complainant also alleged that after receiving a directive to screen the case with the State's Attorney's Office, the CPAS waited a month before screening the case.

INVESTIGATION IG investigators found that following the car accident, in which the mother and her two-year-old toddler sustained life-threatening injuries because the mother was intoxicated with a blood alcohol level of 1.86 and her child was not properly restrained, the assigned CPAS did not complete basic tasks in the child protection investigation for over seven weeks, putting the family at risk and delaying necessary services.

Following assignment, the CPAS went to the hospital to see the two-year-old child victim and interview the father. The plan was for the father to care for both his 6-month-old child and his two-year-old child upon discharge. The CPAS was instructed to assess the father's home and the grandmother's home, who was caring for the mother's 6-year-old child at the time. The CPAS documented concerning behavior by the father when he reported that he allowed the intoxicated mother to drive the children, and he personally buckled the 2-year-old in the car without a car seat. Despite the supervisor's directives, the CPAS made no attempts to assess the father's home or the grandmother's home, notify the mother of the investigation, assess the safety of the siblings, or add the father as a subject of the investigation until seven weeks after the two-year-old was discharged home from the hospital. At the same time, a LEADS request was submitted. Had the CPAS obtained a LEADS request within 48 hours, as required, they would have learned of the father's extensive criminal history.

The CPAS completed the initial Child Endangerment Risk Assessment Protocol (CERAP) as safe and cited the plan to have the father care for the child once discharged from the hospital but did not complete another CERAP until seven weeks after the child was discharged. The CPAS also did not confirm that the parents had adequate car seats for all the children until almost three months after the initial report. In addition, the siblings were never added as alleged child victims, though the mother later admitted that all three children were in the car prior to the accident.

The CPAS delayed the family receiving necessary services when, following the family's refusal for intact services, the CPAS did not screen the case until 24 days after the supervisor's directive to do so. Additionally, during the 24-day lapse in screening the investigation there was no attempt to monitor the continued well-being of the children.

IG investigators found that though the CPAS was not completing basic tasks in this investigation, the CPAS was often working large amounts of overtime during the same time period. According to a review of the CPAS's timesheets, IG investigators found that the CPAS worked over 285 hours of overtime for the month the CPAS was assigned the investigation (including her regular work hours, this averages to 14 hours every single day for the month). For the following three months, the CPAS worked 250 hours, 271 hours, and 222 months of overtime respectively.

RECOMMENDATIONS **1. The CPAS should be disciplined for failing to assess the safety of the father's home and the other children in the home in a timely manner and failing to screen the case with the state's attorney's office in a timely manner as directed by the supervisor.**

The Department has initiated the disciplinary process.

2. This report should be shared with the CPAS's current supervisor for supervision purposes.

The report was shared with the employee's current supervisor.

3. DCFS Management should review the CPAS's workload and schedule to assist the CPAS in better managing their time to ensure critical investigative tasks are prioritized.

DCFS Management has and will continue to review the CPAS's workload and schedule, to assist with time management, to ensure critical investigative tasks are prioritized.

General Investigation 7

COMPLAINT The Department allegedly mishandled a child abuse and neglect investigation of bone fractures to twin infants by their parents. At the time of the complaint, the investigation had been pending for 200 days.

INVESTIGATION The Department initiated an investigation of bone fractures by abuse (#9) against parents of 4-month-old twins. The first twin was hospitalized for fussiness and upon further examination, a radiologist noted multiple rib fractures to the infant and reported the injuries to the Department as suspicious for abuse. The child protection specialist interviewed both parents, who had no explanation for the injuries. A board-certified child abuse pediatrician associated with the hospital consulted on the case and requested the infant's twin sibling also be evaluated. Further imaging studies of both infants revealed 12 fractures to the infant and two fractures to the infant's twin sibling. The board-certified child abuse pediatrician submitted an opinion to the Department during the pending investigation and documented that the infant sustained 12 fractures: 11 to the ribs and one to the tibia. The doctor noted that posterior rib fractures had high association with abuse. The doctor ruled out that the fractures occurred during birth as prior x-rays showed no evidence of fracture and lab results demonstrated sufficient vitamin D levels. The board-certified child abuse pediatrician provided a medical opinion that the infant's fractures were inflicted and due to child physical abuse. The same doctor also found the twin sibling to have abusive fractures noting the injuries were not consistent with birth trauma and appeared acute.

From the onset of the child protection investigation, the parents asserted that their infants had not been abused, and they did not believe the infants had bone fractures. The parents further reported not feeling comfortable with the child abuse pediatrician and sought out additional medical opinions of their own, hired an attorney who threatened the Department with lawsuits, halted communication with the family, and submitted a complaint against the Department to a local elected official. Department management became involved in decision-making for this case and determined the case required consultation from an out-of-state child abuse pediatrician, citing that the parents had a right to additional opinions, and Department management wanted to avoid the appearance of bias.

Department management instructed the child protection investigator to provide the identified out-of-state child abuse pediatrician with records to review to provide an opinion on the infants' bone fractures. At this point, the child protection investigation had already been pending for six months. During this time, the infants remained in the home with their parents and two older siblings, ages 3 and 4, with no monitoring by the Department as the parents refused access. The out-of-state medical provider submitted preliminary findings to the child protection investigator after seven months that also opined the injuries to be abusive. For the next five months the child protection specialist and supervisor attempted to obtain a final report on letterhead from the out of state provider, who ultimately never responded.

Eighteen months after the Department initiated the investigation, the child protection specialist and supervisor completed a critical decision to indicate the investigation for bone fractures by abuse (#9) to an unknown perpetrator as there had been multiple caregivers of the infants at the time of injuries. The child protection specialist reported awaiting instruction from DCFS Office of Legal Services regarding the need to complete the closing CERAP. During this time, the field waited for DCFS Office of Legal Services

to speak with the family's attorney regarding a final visit to the home. The extensions during this time cited the need for DCFS Office of Legal Services to advise on the closing CERAP. A lack of communication and coordination between the field and legal services led to this investigation remaining open for an additional eight months. In all, the investigation remained pending for over 800 days, requiring 25 extensions, taxing an already overburdened child welfare system.

RECOMMENDATIONS **1. In cases where a medical opinion has been provided from an Illinois board-certified child abuse pediatrician, during a child protection investigation, the Department should limit utilization of second medical opinions to only those cases in which the DCFS Medical Director identifies concerns with the quality or veracity of the original medical opinion.**

During a child protection investigation, if the Department obtains a medical opinion from an Illinois board certified child abuse pediatrician, and thereafter the parent(s) obtain a conflicting medical opinion, the Department will consult with the DCFS Medical Director to determine whether there are any concerns with the quality or veracity of the original medical opinion. If any such concerns are identified, the Department will consider seeking an independent second medical opinion.

2. The report should be shared with the DCFS Medical Director.

The report was shared with the DCFS Medical Director.

3. The Division of Child Protection Administrators who approve extensions citing a need for involvement with the DCFS Office of Legal Services, should be required to follow-up with the DCFS Regional Counsel.

The Department agrees that coordination between divisions is important particularly if it impacts the ability to close a child protection investigation. A Practice Memo was issued to all child protection Area Administrators to share with their teams advising child protection staff that if they are requesting or approving an extension on an investigation due to the need for consultation, intervention, or action by the Office of Legal Services, to contact their Regional Counsel to advise them of the need for legal assistance.

4. The report should be shared with the Department's General Counsel. The Department's General Counsel should review the redacted emails involving the Office of Legal Services and take appropriate action with involved staff and consider a mechanism to address timely communication and coordination between child protection staff and DCFS Office of Legal Services attorneys.

The Department's General Counsel reviewed this report and emails between OLS and the field regarding this case. The Office of Legal Services will work with the Division of Child Protection to consider how to improve coordination and communication between the divisions.

General Investigation 8

COMPLAINT A placement worker assigned to the case of a mother and her five-year-old child was allegedly not visiting the family.

INVESTIGATION The OIG investigation did not substantiate the allegation that the placement worker was not visiting the family. However, the investigation identified patterns of poor practice regarding the placement worker's documentation in contact notes in this family's case as well as additional cases assigned to the placement worker.

The family's placement case was open for three and a half years. During the first year and a half, the mother struggled with untreated mental health, substance misuse and was inconsistent with parent-child

visitation. The mother later began to engage in services and parent-child visitation increased. Almost three and a half years after the Department was granted temporary custody of the child, the child was returned home to his mother's care, under an order of supervision. At a court hearing three months later, the case was closed but no after care services were provided in violation of 705 ILCS 405/2-28 (Court Review).

The placement worker's contact notes made it difficult to ascertain the mother's progress throughout the case, particularly when she began to engage in services. The placement worker's contact notes were duplicated month to month and often contradicted other contact notes from the same time period. Maintaining client contact notes is essential for delivering consistent, professional and effective service delivery. Client contact notes are a valuable tool used by the court as well as service providers to make critical decisions. In this case when a psychologist conducted an evaluation of the mother which was comprised of interviews and casework documentation, the psychologist noted that the frequency of duplicate notes made it very challenging to develop an accurate timeline of events and adequately assess the mother's progress. Although IG investigators were unable to substantiate whether the placement worker's contact notes were falsified, the duplicated contents of the contact notes call in to question their accuracy. In addition, the placement supervisor reported to IG investigators that she had never noticed duplicated contact notes despite a large volume of duplicated contact notes across multiple cases assigned to the placement worker.

IG investigators identified 19 contact notes in this family's case record that were duplicated word for word. In reviewing additional cases that had been assigned to the placement worker, IG investigators found that in ten additional placement cases, contact notes were also duplicated.

Currently the Department is able to track duplicated contact notes through the Augintel search query, Duplicate Notes. IG investigators found that in the Augintel Duplicate Notes query search, the placement worker was identified as a caseworker that frequently duplicated contact notes going back nearly two years.

RECOMMENDATIONS

1. The Office of the Inspector General will share a redacted copy of the report with the CWCA assigned to the placement case. The CWCA should share and review the report with the placement worker and supervisor to strengthen practice and address documentation errors.

A redacted copy of the report was shared with the CWCA leadership. In response to the report, the CWCA implemented performance improvement plans and comprehensive staff training to address the issues identified in the report.

2. The Office of the Inspector General will share a redacted copy of the report with the Agency Performance Monitoring and Execution (APME) team assigned to the CWCA to address training needs related to documentation errors and after care requirements.

A redacted copy of the report was shared with APME.

3. The Department should consider notification to supervisors when a case has been identified in the Duplicate Notes query in Augintel.

Augintel does have the capacity to identify duplicate notes. This is currently being piloted. When cases with duplicate notes are identified, an email is generated to the team supervisor and Area Administrator with the notification. Once the piloting phase is complete, it will be rolled out further, along with guidance to the field.

General Investigation 9

COMPLAINT During the course of three prior OIG investigations, IG investigators identified a pattern of inadequate or non-existent vetting of an employment candidate's prior employment history, which resulted in the hiring of employees with significant employment-related prior discipline and harmful conduct. Drawing on the findings from the three separate investigations, this investigation explored the systemic hiring practices, which leads to deficient vetting of prospective employment candidates.

INVESTIGATION The OIG conducted a comprehensive review of three hiring cases that revealed deficiencies in obtaining, reviewing, and considering prior employment disciplinary history; a disjointed candidate bypass procedure; and a lack of standardized practice of identifying inconsistencies in reported employment history.

As part of a prior OIG investigation, IG investigators reviewed the employment history of a DCFS employee who had been employed with the state for 22-years at seven different state agencies prior to their employment with DCFS. In a review of the personnel files from those other state agencies, IG investigators found a significant history of erratic and harassing behavior that included physical threats to employees across multiple agencies. The employee's behaviors resulted in multiple fitness for duty evaluations and progressive discipline. Eight months prior to being hired at DCFS, the employee resigned from the previous state agency in lieu of discharge with no reinstatement rights for alleged homicidal threats to co-workers. IG investigators found that DCFS hired the employee without contacting the prior state employers to obtain any discipline history which could have been used as justification for bypassing the candidate.

IG investigators also learned that after being hired by DCFS, the employee continued aggressive and disruptive behaviors toward current DCFS and former coworkers of other state agencies. Because DCFS labor relations was unaware of the prior disciplinary history, no progressive discipline was sought and instead of building on a prior agency's 30-day suspension, the employee was issued non-disciplinary counseling for a first offense followed by a one-day suspension for a second. A third disciplinary intervention was pending when the employee sought a transfer to a different state agency. Instead of informing the new agency of the pending disciplinary charges, DCFS labor relations suspended the charges and in an internal memo noted that if the employee were to return to DCFS, labor relations would resume the disciplinary process. Four months later the employee returned to DCFS due to a technical problem with the initial transfer, however the prior discipline was not pursued. The employee was later terminated as a result of the separate OIG investigation of the employee's pervasive harassment and threats to former coworkers. IG investigators referred findings of harassment and threat to prior co-workers to the Illinois State Police Division of Internal Investigations. The employee was later criminally charged and convicted of Harassment Through Electronic Communications.

In the second case, IG investigators learned that a DCFS employee transferred from another state agency to DCFS with substantial prior progressive discipline including a 30-day suspension. IG investigators learned that DCFS human resources personnel were aware of the discipline and correctly sought out the discipline information from the prior agency. DCFS labor relations approved a bypass of the employee and requested Central Management Services' approval as per the state hiring procedure. IG investigators found that a breakdown in communication within human resources resulted in the employee being hired.

In the third case, IG investigators found that a DCFS child protection specialist had previously worked for a County Sheriff's Office and that during that employment, the employee allegedly harassed and agitated an inmate with mental illness, filmed the interaction and posted the recording to social media. During an internal investigation conducted by the Sherriff's Office, the employee resigned. In addition, IG investigators found that the DCFS child protection specialist also previously worked at another state

agency and resigned with no reinstatement rights under investigation from that state agency. The resignation qualification of "no reinstatement rights" for this employee was not entered into the statewide employee database.

IG investigators found that the employee applied for a DCFS position via the State of Illinois online employment application website SuccessFactors. As part of the application the employee entered historical employment information and provided a resume. IG investigators compared the employee's resume and SuccessFactors and found that the employee failed to report prior employment with the Sherriff's office. Additionally, IG investigators found large discrepancies in historical employment information between the employee's resume and SuccessFactors. When questioned by IG investigators, the employee admitted that they did not list their prior employment with the Sherriff's Office as they did not want DCFS to learn of the prior discipline. The employee further stated that they manipulated the historical employment information on their resume to avoid the appearance of a gap in employment history. The OIG found that DCFS does not have a system to verify employment history, and not all staff have access to electronic historical employment data, including SuccessFactors and the Central Management Services' Personnel History Inquiry screen.

RECOMMENDATIONS **1. With full recognition that the CMS Comprehensive Employment Plan is the ultimate authority for the hiring process for state agencies, there are steps DCFS can take within the CMS parameters to ensure DCFS employs individuals who are best suited to serve our vulnerable population. The Department should incorporate the following changes in Office of Employee Services (OES) written procedures:**

- **OES should ensure that all transactional and labor relations staff have access to electronic historical employment data, including SuccessFactors and the Illinois Department of Central Management Services' Personnel History Inquiry screen in IMSA. In addition, staff should be trained on how to use the data systems.**
- **Past employment data should be reviewed for inconsistencies compared to what the candidate documented on their application. When significant discrepancies in past employment are identified, greater scrutiny should be applied and additional information requested from prior employers.**
- **When a DCFS employee transfers to a new state agency, DCFS should inform the new state agency of any pending discipline or a pending disciplinary investigation involving the employee at the time of transfer. In the event an investigation involving the employee is pending, if appropriate, the employee should not be permitted to transfer until the investigation has concluded.**
- **In the case of external candidates, the Department should send verification letters to at least two former employers. If the most recent employment was for more than seven years, only one verification letter should be required. When responses are not received, OES staff should follow up with the prior employer.**
- **The OES candidate bypass process should be reviewed and amended to ensure that all personnel involved in the hiring process are aware of when a bypass is being sought. OES should develop a mechanism for tracking the status of bypass requests.**

The Office of Employee Services (OES) has implemented a process when conducting the background check of an employee. All Liaison employees are instructed to review the resume, Success Factors (SF), and IMSA when appropriate for prior or current state employment. If in review it is determined a candidate has worked at another state agency Labor Relations will reach out for any past discipline history and personnel will request the last performance evaluation. In the request for the personnel history the liaison will copy their supervisor and the personnel manager.

If adverse information is received the Deputy Director and Labor Relations Administrator will review (if received) the performance evaluation, the discipline history, the background check results and the resume to determine if the agency should move forward with an offer. If the agency decides to not move forward, the Deputy Director will type up the reason for bypass. The reason for bypass is sent to CMS Labor Relations by the DCFS Labor Relations Administrator. A decision is made by CMS Labor Relations. If CMS Labor Relations approves the bypass, an email approval will be sent back to the Labor Relations Administrator. The Labor Relations Administrator will send the email approval by CMS Labor Relations and the request for bypass to the OES liaison, their supervisor and the Personnel Manager, with a carbon copy to the Deputy Director. The OES liaison will upload the CMS approval and the request for bypass into the CMS compliance portal for bypass request. Once compliance makes a decision they will inform the liaison. The liaison will inform the CMS hiring team for permission to move to the next candidate on the bid list.

In reviewing prior employment history (OES) requires candidates to explain gaps larger than 6-months. When those explanations are received the dates reported on the resume are reviewed against the application in success factors. OES conducts an employment verification on one employer in the last seven years or the last two employers. If a discrepancy is identified a reference check is conducted to verify the information. Verifications are completed by attempting to make two phone calls and then mailing a letter. If a discrepancy is identified OES does not move forward with the offer.

In consultation with the Office of Inspector General (OIG) the Department of Children and Family Services (DCFS) have placed employees on administrative leave during an active investigation to prevent their transfer to another agency. When an OES Liaison is contacted by another state agency to confirm a start date, the OES liaison will reach out to Labor Relations prior to confirming a start date with the current DCFS supervisor/manager. If neither the employee nor the other state agency informs DCFS of a transfer we are unable to impact the transfer.

2. For discipline of current DCFS employees, the Department should seek guidance from CMS as to whether progressive discipline can be built upon from a prior state agency, when appropriate.

The Department will clarify with CMS whether progressive discipline can be built upon from a prior state agency, when appropriate.

3. The DCFS employee from the second case should have their discipline history from the prior state agency shared with the employee's current area administrator. The area administrator should facilitate a discussion with the supervisor to ensure increased supervision.

The Department agrees to discuss the prior discipline with the employee's Area Administrator, Regional Administrator and the Deputy Director of Child Protection.

General Investigation 10

COMPLAINT A Child Welfare Specialist (CWS) allegedly engaged in an inappropriate relationship with a father on a case assigned to the worker. The CWS had been assigned to the case for 18 months and had transferred to another Department division at the time of the complaint.

INVESTIGATION The family began involvement with the Department following the birth of a substance exposed infant. That child came into care of the Department eight months later after a domestic violence incident between the parents. A second child came into care after his birth a month later.

IG investigators found that the CWS engaged in inappropriate communication with the father after no longer being the assigned caseworker. The caseworker's state employee phone records showed

that the employee made 92 phone calls to the father's cell phone in a three-month period beginning approximately two weeks after she had transferred off the case. Twelve of the calls were made between the hours of 12:15 am and 4:50 am. A review of text messages showed that on one date, there were 11 text messages between the former CWS and the father; two days later there were 22 messages exchanged, 17 of which were between the hours of 12:30 am and 4:30 am; and two days after that, there were 15 messages, 8 of which were between 12:10 am and 12:20 am. The content of the text messages documented inappropriate communication between a caseworker and former client and was highly suggestive of a romantic relationship. In addition, the former caseworker made 66 calls to the father from her personal cell phone after she was no longer assigned the case. Ring door camera footage from the father's home also documented inappropriate communication between the former caseworker and the father. The CWS denied any inappropriate relationship but acknowledged extensive phone conversations with the father in an attempt to mitigate conflict between the parents. The CWS said the contact continued after her transfer to another division because she had been a source of support for the parents. The CWS also explained that some of her clients use the worker's personal cell phone for contact because they do not always bring their work phone home and there are times contact was needed after hours. The CWS also reported that a friend that the father and the worker had in common used the worker's phone to communicate with the father.

As child welfare specialists are granted great authority in making recommendations about children returning home to their parents, it is imperative that they maintain respect and professional boundaries in interacting with clients.

As noted in the DCFS Employee Handbook:

> Employees of the Department are in positions of public trust and are expected to refrain from conduct which could affect adversely the confidences of the public in the integrity of the Department of Children and Family Services. Employees are expected to conduct themselves in a responsible professional manner in all work situations, whether dealing with clients, co-workers or the general public.

In explaining her communications with the father, the CWS described herself as a source of support to both parents. However, the content, timing and nature of the communication with the father would lead a reasonable person to the conclusion that the relationship between the worker and the father crossed professional boundaries. The worker's explanation that a friend used both the worker's personal and work cell phone without her knowledge was not credible.

RECOMMENDATIONS **1. The Department should pursue disciplinary action of the worker up to and including discharge, for engaging in an inappropriate relationship with a former client in violation of the DCFS Employee Handbook and the Code of Ethics for Child Welfare Professionals.**

The employee resigned from the Department with no reinstatement rights.

General Investigation 11

COMPLAINT A Department employee allegedly accessed information in the DCFS State Automated Child Welfare Information System (SACWIS) and sent a screenshot of the information to their partner. A relative of the partner was the alleged perpetrator/subject of a pending child protection investigation.

INVESTIGATION IG investigators found the Department employee, an Office Associate II, was listed as a designee for several Department employees on the SACWIS system. The designee status allowed the worker to access the SACWIS system, mainly to gather administrative case reviews and enter

case information. IG investigators determined the employee had access to confidential child protection investigative reports via SACWIS.

IG investigators found that the relative of the employee's partner did receive confidential report information regarding the investigation in which they were later indicated. The employee acknowledged to IG investigators that she may have shared confidential information with a family member about the status of a child protection investigation via a text message.

RECOMMENDATIONS **1. The Department should pursue discipline of the employee for a breach of confidentiality in violation of the DCFS Employee Handbook.**

The employee was disciplined.

General Investigation 12

COMPLAINT A child protection specialist (CPS) moved a 4-year-old and 2-year-old from placement with paternal relatives to placement with maternal relatives after the child protection investigation had been closed.

INVESTIGATION The Department became involved with this family after receiving a report that the maternal grandmother, who was caring for the children while the mother was hospitalized and incapacitated following a medical emergency, was using drugs and unable to care for the children. During the child protection investigation involving the maternal grandmother, the non-custodial father signed short-term guardianship for the children to be in the care of the paternal grandparents. The guardianship arrangement specified that the mother of the children, once she regained capacity, had the ability to change the guardian of the children. As the mother recovered, but while still hospitalized, the mother decided she wanted her cousins to care for the children and contacted the CPS for assistance in the change of guardian. IG investigators found that the CPS provided assistance even though the child protection investigation had already been closed. Though the CPS documented her activity in SACWIS, the CPS did not discuss her plan with their supervisor.

The CPS entered notes on five occasions after the investigation closed, documenting speaking with a relative, exchanging text messages with the mother, informing the father of the mother's decision to reassign guardianship and the subsequent exchanges with the father and paternal relatives, including that the paternal relatives requested a formal written notice ending the guardianship. The CPS also documented seeking a written statement of the mother's capacity from the hospital. The CPS informed the paternal relatives that the short-term guardianship had been terminated, involved law enforcement to ensure a smooth transition, and documented that the mother agreed to intact family services. Staff from the Department of Innovation and Technology (DoIT) confirmed for IG investigators that entries can be made in a child protection investigation for up to 60 days after the close of the investigation and that a supervisor would not be notified of additional entries after the date of closure.

The area administrator confirmed for IG investigators that once a child protection investigation was closed the Department should not be involved in moving children and if a family calls them investigators are trained to refer them to the hotline. The administrator reiterated that critical decisions, such as moving children, must be staffed with a supervisor. Additionally, if children were being moved, background checks and the home safety checklist must always be done.

In this case, the timing of the change in guardianship played a part in the difficulties encountered. Only two days after the final supervisory conference, the mother wanted to change the guardian and called the CPS for assistance, not knowing the child protection investigation was closed. As the CPS had assisted with the initial placement change from the maternal grandmother, it seems logical that the

mother would contact the CPS who took it upon themselves to assist. Citing the weekend as a barrier to access a supervisor, the CPS did not consult with their supervisor, but did enter notes into SACWIS to document their activities.

The CPS was in an uncertain position. Given that the CPS had facilitated the short-term guardianship less than two weeks earlier while the mother was incapacitated, it is logical that the family would contact them with requests for assistance, without the family realizing the investigation was closed. It is reasonable to expect that families may have questions or concerns related to short-term guardianship and in situations in which the Department facilitated the short-term guardianship, it is the responsibility of the Department to provide the support and resources families require.

RECOMMENDATIONS

1. This report should be shared with child protection specialist and used by their current supervisor as a teaching tool.

The report was shared with the CPS and used as a teaching tool.

2. This report should be shared with the supervisor.

The report was shared with the supervisor.

3. When short-term guardianship is entered into during a child protection investigation the Department should develop resources and support for families when questions arise about the short-term guardianship after the child protection investigation has closed. Once the resources are developed, the CFS 444-2, *Appointment of Short-Term Guardianship* form should be amended to provide families with contact information for the resources.

In June 2025, the Department's Office of Legal Services issued a memo to Division of Child Protection leadership that focused on Short-Term Guardianship. The memo was shared on June 23, 2025 with Regional and Associate Regional Administrators who were instructed to share the memo with their teams.

General Investigation 13

COMPLAINT A Department employee allegedly used their state issued email account for personal use.

INVESTIGATION The OIG investigation found that during a two-year period, the employee sent over 450 personal email correspondence to the employee's state email account from the employee's personal email account and/or that of family members. The personal emails included personal correspondence, travel itineraries, receipts, bills, bank statements, party invitations, photographs, medical appointments, resume and cover letters. Most of the email correspondence occurred during the employee's normal work hours.

In addition, the OIG investigation found that the employee breached confidentiality and violated Rule 431, *Confidentiality of Personal Information of Persons Served by the Department of Children and Family Services*, when the employee emailed confidential client information through personal email accounts to non-DCFS persons who were not authorized to access the information.

RECOMMENDATIONS **1. The Department employee should be disciplined for violating Rule 431, when they shared confidential client information with persons not authorized to access the confidential information and sent confidential information through private email accounts. The**

employee should also be disciplined for violating Administrative Procedure 20, when they used their stated issued email account for personal correspondence and document transfer during work hours.

The employee was disciplined.

2. The Department's Office of Information Technology Service should review the employee's Department issued laptop and iPhone to ensure that the employee is not accessing personal accounts on these devices.

The Department agrees to review the employee's state issued laptop and iPhone.

General Investigation 14

COMPLAINT A child protection specialist (CPS) allegedly made inappropriate comments of a sexual nature to a mother who was the subject of an investigation to which he was assigned.

INVESTIGATION The child protection investigation was initiated after law enforcement reported that the mother, while intoxicated, was trying to take her 1-year-old child from her young adult daughter. The adult daughter resisted, and an altercation ensued. The 17-year-old sibling of the young adult tried to intervene. The mother hit the 17-year-old child and according to law enforcement, had been arrested.

The assigned investigator completed interviews of the mother, the verbal children in the home, identified collateral contacts, law enforcement, and observed the 1-year-old. The three youngest children were taken into protective custody. At a temporary custody hearing, the judge denied the custody petition and ordered the mother to participate in intact family services.

The mother told IG investigators that during the investigation the CPS asked her questions about her relationship status and shared personal details about himself including his hobbies, dating persons who were in the same profession as the mother and battling a former drug addiction.

Before closing the investigation, the CPS called the home and made a remark about the CPS and the mother getting together in two years. A witness, who had overheard a phone conversation between the mother and the CPS, confirmed that before the phone conversation, the mother had told the witness that the CPS had made her uncomfortable with sexualized statements. The witness was at the home when the CPS called, and the mother had the CPS on speaker phone. During the call, the CPS notified the mother that his investigation would be indicated and then proceeded to suggest the mother call him in two years "when things could work between us." The CPS then informed the mother he would be coming by the house in a few days to see her and the children. The intact worker corroborated that the mother had shared the same concerns with her.

The CPS initially denied saying anything inappropriate to the mother but later reported that he had made a remark about calling in two years. The CPS reported the mother had been flirting with him throughout the case and had texted him, though they did not reply. The CPS said he believed the mother was scared of being indicated for abuse, so she had been flirting with him. The CPS acknowledged that he should not have said anything about a potential future relationship.

Because child protection specialists are granted the authority to take children into protective custody if the children are in danger, an unequal power dynamic exists. As such, in that role it is imperative that child protection specialists, as well as all child welfare professionals, maintain boundaries and respect in their interactions with clients. As noted in the DCFS Employee Handbook:

> Employees of the Department are in positions of public trust and are expected to refrain from conduct which could affect adversely the confidences of the public in the integrity of the Department of Children and Family Services. Employees are expected to conduct themselves in a responsible professional manner in all work situations, whether dealing with clients, co-workers or the general public.

While the handbook sets forth a two-year prohibition of romantic relationships with former clients, voicing that to the client at the time of the investigation communicates a possible ulterior motive. The indicated finding in this child protection investigation appears appropriate, however, the CPS, in making sexually suggestive remarks, could have compromised the integrity of the investigation.

RECOMMENDATIONS **1. The child protection specialist should be disciplined for conduct unbecoming a state employee.**

The employee was disciplined.

2. Following any disciplinary action, this report and the ethical implications should be reviewed and discussed with the child protection specialist by the Division of Child Protection management.

The report was reviewed and discussed with the child protection specialist regarding the ethical implications.

General Investigation 15

COMPLAINT A Department Child Welfare Specialist was allegedly having an inappropriate relationship with a client on his caseload.

INVESTIGATION An intact family services case opened following a domestic dispute involving the mother and a male friend during which her then 1-year-old child was present. According to the initial Integrated Assessment, recommended services included parenting, domestic violence services, and mental health services. Mother was not compliant with services, did not meet with her intact worker regularly, and her whereabouts were unknown for months, resulting in a referral for court supervision. Seven months later, while the intact case remained open, the hotline was contacted with allegations of #60-Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect to mother's toddler and newborn child. The reporter stated that mother recently tested positive for drugs; had a history of drug use; and was recommended to engage in services but had not. The mother was indicated, and the two children were taken into protective custody. Following protective custody, the intact case was closed, and the Department opened a placement case.

The CWS was the assigned placement worker for 15 months. During this time, mother's compliance with services continued to be an issue and she continued to test positive for substances. The goal as to the younger child was changed from Return Home to Substitute Care Pending Termination of Parental Rights and ultimately mother's rights to that child were terminated. The older child had been placed with their father.

Prior to the termination of parental rights as to the younger child, the CWS learned that mother was pregnant with her third child. Mother informed the CWS that her brother was willing to take the child and CWS arranged to visit the brother's home.

When the mother gave birth to her third child, the hospital contacted the hotline to report that the infant tested positive for amphetamine and an investigation opened for allegations of #65-Substance Misuse by Neglect and #60-Substantial Risk of Physical Injury/Environment Injurious. The assigned child protection specialist took protective custody, and the newborn was placed in the traditional foster

home with their sibling. During a telephone conversation with the assigned CPS, mother alleged that her placement worker was trying to pressure her into having sex with him, saying he could help her get her kids back. The mother alleged that her placement worker made sexual comments, would randomly come to her house and sit there for hours, and contacted her through social media.

IG investigators could not substantiate the complaint of an inappropriate personal relationship with a client. In his OIG interview, the CWS denied any quid pro quo offers and denied making promises to help mother in exchange for anything. While mother repeated her allegations to IG investigators, she did not provide the corroborating evidence she reported that she had. In addition, phone records obtained by IG investigators showed no phone calls or text messages from the CWS' personal cell phone to either of the two telephone numbers identified as the mothers.

The CWS admitted to using social media with mother, stating that he was trying to be a friend and was trying to help her. The CWS told IG investigators that he never communicated anything inappropriate. The CWS denied that his supervisor was aware that he was using social media and said he did not use it with any other clients.

The Code of Ethics for Child Welfare Workers notes that workers are in positions of authority and the onus is on the worker to establish boundaries and maintain the relationship as professional. In the age of digital communication, establishing boundaries around the use of social media and technology are critical. Workers should be discussing communication with supervisors to help establish and maintain the boundaries. These boundaries are important for maintaining professionalism and preventing connections with clients on social media that could blur professional boundaries. Social media connections with clients should be transparent, have supervisory approval and be avoided when possible.

RECOMMENDATIONS **1. A redacted copy of the report should be shared with the Child Welfare Specialist and their current supervisor for training related to ethical boundaries and the inappropriate use of social media with clients.**

A redacted copy of the report was shared with the CWS and the current supervisor to be used as a teaching tool.

ERROR REDUCTION TRAINING

In 2008, the Illinois General Assembly enacted Error Reduction legislation requiring the Office of the Inspector General to develop Error Reduction Implementation Plans to remedy child welfare practice errors that compromise or threaten children's safety, based on findings of the Inspector General's investigations and the Child Death Review Teams recommendations. 20 ILCS 505/35.7.

The basis for error reduction legislation was a recognition that organizational practices can contribute to potentially tragic outcomes for children, including death or serious injury. The Inspector General's training curricula grew from legislation introducing the concept of error management – i.e. strategies to prevent the occurrence of tragic errors by applying error reduction techniques to cases involving cuts, welts and bruises, mental health, substance misuse\abuse, and egregious acts of physical abuse. The Inspector General has developed and presented numerous field trainings designed to address and reduce such errors.

Data Driven Implementation

In FY 2025 the Office of the Inspector General (OIG) Error Reduction Team developed a framework to collect data on errors and missteps identified during OIG death investigations and deaths reviewed by the OIG. Through consultation with UIS faculty and other experts, ERT staff defined and developed a code of errors from the field to identify areas of concern and trends through data driven analysis. This process will inform future training for Department staff and provide feedback regarding ways to improve practice and service Illinois' most vulnerable populations.

Training Issue: Decision-Making in Child Protection

OIG investigative findings and recommendations issued over the past five years have addressed errors made during child protection investigations of abuse and neglect. Between FY 2021 and FY 2024 the OIG referred eleven death investigations to the Error Reduction Team for inclusion in training and curriculum development. In all eleven investigations, the family had prior involvement with the Division of Child Protection in the 12 months preceding the death. Through review and analysis of these investigations the Error Reduction Team identified common errors that influenced decision making that impacted child safety and wellbeing.

Curriculum development for FY 2026 focused on providing guidance on how errors in child protection investigations impact decision making and child safety. Aims of the FY 2026 curriculum included strengthening critical thinking and decision making for the staff who provide some of the most critical work of the Department, investigation, assessment, and intervention with families. The training will explore, with the use of vignettes, how errors in use of family history, basic investigative tasks, bias, and communication directly impact decision making around safety and risk assessments as well as substantiation of findings and service referrals. The training will also combine evidence-based research to strengthen staff knowledge on decision making and reasoning when working with families.

As part of the new training development, OIG ERT staff reviewed previous training evaluations from Department and CWCA supervisors and managers. One of the top challenges identified by attendees included implementing training knowledge with their team and a continued need for front line staff training opportunities. Given this feedback, the FY 2026 plan submitted to the Director of DCFS focused on training direct staff, beginning with child protection investigators.

DEPARTMENT UPDATE ON PRIOR SYSTEMIC RECOMMENDATIONS

The Office of the Inspector General's systemic recommendations are designed to strengthen the child welfare system to better serve children and families. The OIG tracks and monitors the implementation of recommendations accepted by the Department. The Department is in the process of implementing a new safety assessment tool, SAFE Model, and the new technology information system, IllinoisConnect, which will address many prior recommendations related to safety planning and technology improvements. Where feasible, the Department has begun deploying interim practice improvement measures and front-line guidance to address recommendations until the systems are fully implemented.

The following systemic recommendations were made in prior fiscal years and were pending when last year's OIG Annual Report was issued. The Department's current implementation status is detailed below in the following categories:

- Child Protection
- Intact Family Services
- Personnel
- Services
- Technology

Child Protection

FY 2024 **The Department should use this report in training staff on the Department's new safety decision tool, the SAFE model. This training should provide direction to staff when a child cannot be located or interviewed to assess their safety (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 6).**

2025 Department Update: The report has been shared and will be used in the new SAFE Model training.

FY 2024 **The Department in conjunction with the Office of Legal Services and Division of Child Protection should explore the limitations of a binary system of indicated or unfounded for child protection findings and the feasibility of an alternative finding to address circumstances when child protection investigators are unable to obtain the needed information to make a determination of indicated or unfounded (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 6).**

2025 Department Update: The Child Death Review Team and the Office of Legal Services explored the feasibility of using the "undetermined" finding in circumstances when investigators are unable to obtain sufficient information to make a clear "indicated" or "unfounded" determination. While the current binary system has limitations, using "undetermined" as a final finding would be inconsistent with the requirements established in the Illinois Abused and Neglected Child Reporting Act, 325 ILCS 5/7.12 and therefore is not possible at this time. The Department also considered the use of subcategories within the unfounded final finding to identify investigations in which an alleged victim could not be located and has determined not to pursue this change. The Department recognizes the importance of supporting thorough and diligent investigations, while also accurately reflecting circumstances in which a final finding is reached without direct contact with the alleged child victim due to inaccessibility or an inability to locate the child or family. To support transparency and consistency, the Department will provide training to child protection staff on clearly documenting investigative efforts, including situations in which an extension is requested because the alleged victim or family was inaccessible or unable to

be located. The Department will also continue to track the number of investigations that are unfounded due to an inability to locate the alleged victim or family, to identify any trends or increases in that type of investigative barrier.

FY 2024 **The Department, in collaboration with the DCFS Medical Director and Statewide Medical Consultation Providers, should develop training materials and posters to educate the field on fractures. Materials should include but not be limited to differentiating between accidental and inflicted injuries; prevalence and risk factors associated with inflicted injuries; and mechanism of injury (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 5).**

2025 Department Update: Training materials have been developed to educate the field on bone fractures. In addition, there is a Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC) training series which includes a 90-minute virtual training on bone fractures that is offered twice a year.

FY 2024 **In this case, the rationale provided by the child protection investigator for requesting waivers was not appropriate. The Department should consider requiring that both the investigator and supervisor enter the reason for requesting and/or approving waivers in the checklist tab of SACWIS. This requirement should be incorporated in the Department's new data information system (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 8).**

2025 Department Update: The recommendation will be incorporated into IllinoisConnect. In the interim, the SACWIS team made modifications to the current Not/Applicable – Waiver Request functionality for Checklist tasks. To increase visibility, the 'radio buttons' were changed to a single dropdown list containing Not Applicable/Waiver Request/None and when either Not Applicable or Waiver Request are selected it expands the area just below the Checklist task being 'waived'. This is where another dropdown list appears for the Contact Missing Reason and for Waiver Explanation narrative, both are required to have a complete record for an approval to take place and allow the investigation to be completed without the Checklist task being completed. Once a Waiver Request is approved, it will complete the record (freeze) so the data elements selected and narrative written cannot be changed (this is current functionality). Current functionality will also remain where the Checklist task (Contact Note) can be completed even if a Waiver was requested and approved.

FY 2024 **The Department's Director of Nursing Services, DCFS Medical Director, the Deputy Director of Child Protection and the Deputy Director of Clinical Practice should meet to discuss this report and develop a practice memo for the field about the role of DCFS Nurses in child protection investigations, including investigations involving medical neglect and children with complex or chronic medical issues. As previously recommended in an OIG report, the practice memo should provide the field with guidance on obtaining information, identifying barriers and working with identified community providers around issues identified during the child protection investigation. The practice memo should be incorporated in Procedures 300.140(d) (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 2).**

2025 Department Update: The Department's Director of Nursing Services, DCFS Medical Director, the Deputy Director of Child Protection and the Deputy Director of Clinical Practice met, reviewed, and discussed the report and developed a practice memo targeted at child protection investigators and the role of nurses for medically complex cases. The practice memo coincides with Procedures 302 and will be issued to child protection, permanency and intact staff. In addition, the nursing division has provided in-service training to child protection staff throughout the state on the role of the nurses and use of the CFS-531, Nursing Referral Form. The Chief Nurse has also conducted meetings with staff to review policy, the referral process, expectations, and the role of DCFS Nurses.

FY 2023 **The Department should develop and require training for temporarily assigned supervisors who are currently employed as Child Protection Specialists and Child Protection Advanced Specialists (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 1).**

2025 Department Update: A workgroup that consisted of child protection supervisors, area administrators, and Office of Learning and Professional Development staff developed a training for child protection specialists entitled, Training for Temporary Assigned (TA) Child Protection Public Service Administrators. The training can be found online in the DCFS Virtual Training Center.

FY 2023 **The Department, in collaboration with the DCFS Medical Director and Statewide Medical Consultation Providers, should develop training materials and posters to educate the field on burns. Materials should include but not be limited to, differentiating between accidental and inflicted injuries; prevalence and risk factors associated with inflicted injuries; and mechanism of injuries (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 5).**

2025 Department Update: The DCFS Chief of Nursing, in collaboration with the DCFS Medical Director completed the development of the training materials. The training was offered to DCFS Nurses and child protection staff. In addition, there is a Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC) training series which includes a virtual training on this topic that is offered twice a year.

FY 2023 **The Department should use this report in training staff on the new SAFE model. This training should specifically address assessing the safety of children in the hospital and use of informal care plans (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 9).**

2025 Department Update: The report has been shared to be used in training materials along with other identified closed cases.

FY 2023 AND FY 2021 **In the absence of the Public Service Administrator, only the Child Protection Advanced Specialist or Area Administrator should be allowed to approve a Child Endangerment Risk Assessment Protocol and/or provide a Final Supervisory Decision (from January 2022 OIG Annual Report, Death and Serious Injury Investigation 6 and from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 1).**

2025 Department Update: Due to the drastic difference between the number of teams within the Division of Child Protection (DCP) and the number of child protection advanced specialists within DCP, there are feasibility concerns with meeting this request. To better equip child protection specialists, a workgroup that consisted of child protection supervisors, area administrators, and Office of Learning and Professional Development staff developed a training for child protection specialists entitled, Training for Temporary Assigned (TA) Child Protection Public Service Administrators. The training can be found online in the DCFS Virtual Training Center.

FY 2022 **Procedures should require that when a child protection investigator learns that a child 1 month old to 12 months old has never been seen by a doctor, the child protection investigator should take proactive efforts, in consultation with their supervisor, to have the child medically evaluated (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 5).**

2025 Department Update: The Office of Child and Family Policy is working on procedural revisions that will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect. The recommendation will be incorporated in these updates.

FY 2022 **The Department should create policy for when and how to use temporary guardianship during a pending child protection investigation (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 3).**

2025 Department Update: The recommendation will be incorporated into revisions to Procedures 300.50, Procedures 300.130 and Procedures 302.389. The revisions will include instruction on how to use short-term guardianship, including, when it might occur during an investigation where there is not present danger, due to abuse or neglect. These procedural changes will be part of the conversion to

the SAFE Model. The Office of Child and Family Policy is also working on procedural revisions that will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect. In addition, Office of Legal Services facilitated a training discussion regarding temporary guardianship. Office of Legal Services will prioritize developing training materials regarding this topic for future trainings.

FY 2022 **When temporary guardianship is utilized during a pending child protection investigation in lieu of protective custody, the Department must offer a minimum of Extended Family Support Program Services (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 3).**

2025 Department Update: The recommendation will be incorporated into the Department's conversion to the SAFE Model. In addition, the Office of Child and Family Policy is working on procedural revisions that will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect.

FY 2022 **The Department should amend the CFS-2040, *Division of Child Protection- Intact Family Services Case Referral and Assignment Form* to reflect notification to the referring person of whether the case has been accepted, denied, or if more information is needed to make a determination and that mechanism should be built into the Department's new data information system (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 4).**

2025 Department Update: The recommendation was incorporated into revisions to the CFS 2040, Division of Child Protection- Intact Family Services Case Referral and Assignment Form and CFS 2040WR, Intact Family Services Weekly Report. The revised forms were released via 2023.13 Informational Transmittal which was sent out as an announcement and an email to staff on December 29, 2023. The revised forms can be found on the Department's templates drive. In addition, the workflow capabilities of IllinoisConnect will support automated notifications to the referring person.

FY 2022 AND FY 2021 **The Department should amend Procedures 300, Appendix B, Allegation of Harm #79-Medical Neglect to include the following required activity, "If a child has special health care needs, as defined in Procedures 302, Appendix O, Referral for Nursing Consultation Services, the Child Protection Specialist must complete a DCFS nurse referral." (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 11 and January 2022 OIG Annual Report, Death and Serious Injury Investigation 1).**

2025 Department Update: On March 4, 2024, the Department's Chief Nurse issued a memo to child protection staff titled, Nurse Referral Update-Allegation 79 Medical Neglect. The memo reminded staff that in accordance with Procedures 302, Appendix O, a nursing referral should be made during the investigation of Allegation 79, Medical Neglect, when a child has been identified as having a chronic or acute health condition requiring medical supervision or intervention beyond normal medical care. In addition, the recommendation will be incorporated into procedural revisions that will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect.

FY 2021 **The Department should establish procedures for developing and monitoring care plans during child protection investigations and for informing parents of their rights in the event a care plan is put in place (from January 2022 OIG Annual Report, General Investigation 7).**

2025 Department Update: The Department agrees and is in the process of implementing a new Safety Decision Tool called Safe Assessment and Family Evaluation (SAFE), that will address the OIG recommendation by including a mechanism to ensure the safety of children when absent a determination of "UNSAFE" but there is an agreement by the family to make care plans formally.

FY 2021 **In child protection investigations involving facility reports in which biological children are involved, the Department should modify procedures/SACWIS to allow the Child Endangerment Risk Assessment Protocol to be conducted on the biological/adopted children (from January 2022 OIG Annual Report, General Investigation 7).**

2025 Department Update: The Department is in the process of replacing the CERAP with a new safety decision tool called Safe Assessment and Family Evaluation (SAFE). The recommendation will be incorporated in the Department's new safety decision tool.

FY 2020 **The Department should communicate a more consistent application of "blatant disregard" to child protection staff (from January 2021 OIG Annual Report, Death and Serious Injury Investigation 5).**

2025 Department Update: The recommendation was addressed in a Practice Memo dated November 16, 2022, that was shared with Child Protection staff, the Office of Learning and Professional Development staff, regional administrators and area administrators with the direction to share at the team and worker level. Additionally, the Department is in the process of revising Procedures 300 which will address the consistent application of the definition of "blatant disregard." The revisions will encompass the Department's new safety decision tool titled Safe Assessment and Family Evaluation (SAFE) which will include revisions to the Allegation system. The procedural revisions will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect. The Department will incorporate the provisions outlined in the November 2022, Practice Memo, into revisions to Procedures 300.

FY 2019 **The Department should consider strengthening Procedures 300.80, *Child Protection Supervisor/Area Administrator Waivers*, when an alleged child victim is inaccessible and ensure investigators are trained accordingly (from January 2020 OIG Annual Report, General Investigation 13).**

2025 Department Update: The Department is conducting an overall revision of Procedures 300, including Section 300.80, Child Protection Supervisor/Area Administrator Waivers which will address the steps investigators must take when an alleged child victim is inaccessible or otherwise unable to be seen in the proper time period. This rewrite will encompass the Department's new safety decision tool titled Safe Assessment and Family Evaluation (SAFE) which will include revisions to the child protection protocols. The procedural revisions will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect.

FY 2005 **The Child Endangerment Risk Assessment Protocol (CERAP) should be amended to require that workers note when a risk factor cannot be answered because of insufficient information. Under such circumstances, workers should be required to perform diligent inquiry into relevant facts for assessment within 48 hours. The Department should develop procedures to ensure that there is follow-up and resolution of unknown variables (from January 2005 OIG Annual Report, Death and Serious Injury Investigation 9).**

2025 Department Update: The Department is in the process of replacing the CERAP with a new safety decision tool called Safe Assessment and Family Evaluation (SAFE). The recommendation will be incorporated in the Department's new safety decision tool.

FY 2023 **The Department should incorporate guidance for field staff on the Intact Family Recovery Program in DCFS Procedures 302.388 e) 2) Case Opening and Initial Case Assignment (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 9).**

2025 Department Update: The Intact Family Recovery Manager has begun conducting training on the Intact Family Recovery referral process for Child Protection investigators, supervisors and area administrators on a quarterly basis. In addition, the Intact Family Recovery brochure was revised September 2023 and reposted on the D-Net on April 4, 2024. The Intact Family Recovery Manager also posts referral instructions on the D-Net on a quarterly basis as well as sending monthly emails to DCP teams informing them of openings in the Intact Family Recovery program. In addition, the Department updated the FY 2026 program plan for the Intact Family Recovery program. Following integration of the SAFE Model and IllinoisConnect, the Intact Family Recovery Program will be incorporated into procedures.

FY 2023 **The Department should ensure that the intact referral process is incorporated into IllinoisConnect to allow for tracking, follow-up, and initiation of services (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 9).**

2025 Department Update: This process will be fully incorporated into the IllinoisConnect system and will allow for an automatic referral and case opening process.

FY 2021 **The Department should review the referral process for Intact Family Services. As this case demonstrates, the timeliness of referrals is an issue, and the referral process is not adequately monitored or enforced. The Department's review of the referral process should address streamlining the process by deleting duplicative or unnecessary steps, delineating a clear path of administrative review to ensure timely referrals, and assessing barriers to referrals (from January 2022 OIG Annual Report, Death and Serious Injury Investigation 4).**

2025 Department Update: The Office of Intact Family Services and the Division of Child Protection developed a new referral form which was issued to the field on February 1, 2024. This form has also been incorporated in revised Procedures 302.388. The procedural revisions to 302.388 will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect and SAFE Model.

FY 2021 AND FY 2019 **The Department should assign a DCFS nurse, for the duration of intact family services cases involving medically complex children. Their duties should include attending home visits with the intact caseworker to meet with the family, attending medical appointments with the family and the intact service worker, communicating with medical providers, assisting with the medical and health related sections of the integrated assessment, and participating in Child and Family Team Meetings to help the family develop a plan to ensure that the children receive their medical care (from January 2022 OIG Annual Report, Death and Serious Investigation 2 and January 2020 OIG Annual Report, Death and Serious Injury Investigation 6).**

2025 Department Update: The Office of Intact Family Services provided training to DCFS nursing staff to review services offered to Intact families. The first training was held on July 25, 2024, and was offered statewide to both DCFS and CWCA providers. The training has been offered twice a year along with refreshers on the medically complex practice memo for intact cases. Additionally, the Office of Intact Family Services will work to develop a system at intake in which referrals will be flagged when a medically complex child is identified. Once a case is flagged as medically complex, it will be put into a rotating review system which will result in quarterly reviews of these flagged cases. If during this review concerns are raised regarding the case, this will trigger a meeting with the assigned agency team, Management Operations Analysts, Agency Performance Monitoring and Execution (APME) staff,

and the Deputy Director of Intact. In addition, the Office of Intact Family Services will develop a training series around common medical complexity issues to be delivered to the field, as well as develop a best practice guide for medically complex cases to be implemented into the current revisions to procedures. The overall intent is to increase consultation with DCFS Nursing Staff.

FY 2019 **At transitional visits in Intact Family Services cases with a medically complex child, the child protection investigator and the intact family services caseworker should request that the parent sign consents for the worker to communicate with the child's medical home provider regarding the child's health and medical care management (from January 2020 OIG Annual Report, Death and Serious Injury Investigation 6).**

2025 Department Update: Procedures 302.388, Intact Family Services, is in the process of being revised. DCFS and Child Welfare Contributing Agency Intact caseworkers and supervisors continue to utilize the October 20, 2023 practice memo which specifically addresses consents to be signed by the parents at the transitional visit with the child protection investigator. The procedural revisions to 302.388, Intact Family Services will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect and the SAFE Model.

FY 2019 AND FY 2017 **For Intact Family Services cases involving medically complex children, the caseworker must convene a staffing, within 30 days of receiving the case, with the health care professionals involved with the family and parent(s) to discuss the child's care and assess parents' needs for tangible and emotional support (from January 2020 OIG Annual Report, Death and Serious Injury Investigation 6 and January 2018 OIG Annual Report, Death and Serious Injury Investigation 8).**

2025 Department Update: Procedures 302.388, Intact Family Services is in the process of being revised. DCFS and Child Welfare Contributing Agency Intact caseworkers and supervisors continue to utilize the October 20, 2023 practice memo which requires a 30-day staffing with all health care professionals. The procedural revisions to 302.388, Intact Family Services will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect and the SAFE Model.

FY 2018 **The Department should explore expanding the Child Welfare Training Academy Simulation residential home for intact family workers and supervisors (from January 2019 OIG Annual Report, Death and Serious Investigation 1).**

2025 Department Update: The DCFS Office of Learning and Professional Development (OLPD) expanded the Child Welfare Training Academy Simulation program to intact family services staff in December 2024. DCFS Simulation Facilitators have been delivering simulations on Utilizing Motivational Interviews in the Child and Family Team Meeting to strengthen practice for Intact and Permanency staff to engage in effective changed focus practice with youth and families. These simulation workshops are open to all DCFS and Child Welfare Contributing Agency Intact and Permanency workers and supervisors. The workshop includes practice with actors provided through Illinois State University and a follow-up debriefing delivered by DCFS facilitators. The simulations are being offered for Cook and Northern Region at the DCFS Child Protection Training Academy (CPTA) simulation lab in Chicago and for Central and Southern at the DCFS CPTA simulation lab in Bloomington/Normal. The simulation workshops are offered monthly in each location.

Personnel

FY 2024 **The Department should require notification to the Division of Labor Relations of Significant Events (Unusual Incidents) involving the arrest, charge, or conviction of an employee to allow for consistent evaluation and monitoring. The Employee Handbook and Department Rules and Procedures should be amended accordingly (from Fiscal Year 2024 OIG Annual Report, General Investigation 9).**

2025 Department Update: The Significant Event Report will be incorporated into IllinoisConnect. IllinoisConnect will have automatic notification to Labor Relations when an employee creates a Significant Event Report involving the arrest, charge or conviction of an employee. The Employee Handbook is also being updated to include the requirement that an employee is to report not only to their supervisor of an arrest, charge or conviction of an employee, but also that Labor Relations be notified.

FY 2024 **The Office of Employee Services, Division of Labor Relations should develop a written protocol detailing the process for evaluating an employee's arrest, charge, or conviction and also determining an appropriate work status in conjunction with the assigned supervisor or administrator (from Fiscal Year 2024 OIG Annual Report, General Investigation 9).**

2025 Department Update: The Office of Employee Services is updating the Employee Handbook under the Standards of Conduct section to address the recommendation. The employee will be required to notify the Division of Labor Relations of any arrest, charge, or conviction at which time Labor Relations will inform the employee of the next steps. The Employee Handbook will outline how the Department evaluates what is considered an arrest, charge, or conviction. The Employee Handbook will also detail the process and procedures the employee must follow and the impact to the employee's work status.

FY 2022 and FY 2023 **The Department should develop written protocol for the use of restricted duty status. The Department should review the practice of placing staff on indefinite desk duty after the death of a child and explore the use of increased supportive supervision in lieu of desk duty, when appropriate (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 11 and from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 3).**

2025 Department Update: The Department's Office of Employee Services drafted guidelines related to restricted duty status that have been reviewed and approved by the Director. The Department is currently in negotiations with the AFSCME labor union regarding finalizing the guidelines.

Services

FY 2024 **The Department should amend Procedures to provide guidance to placement staff on what action should be taken by a placement worker in response to an Information Only (IO) report from SCR staff, such as contacting mandated reporters. The placement worker should be required to follow-up with the information and contact the hotline if abuse or neglect is discovered. In the interim, the email sent by SCR staff alerting placement workers that a report was taken as Information Only should instruct placement workers to follow-up with the information and contact the hotline if abuse or neglect is discovered (from Fiscal Year 2024 OIG Annual Report, General Investigation 3).**

2025 Department Update: The Department agrees that it is important to provide guidance to placement staff on actions to take in response to an Information Only report. When an IO report is received by the assigned case management team, a critical staffing will be conducted including a timely response plan and a determination about whether the information gathered raises concern about suspected child abuse or neglect. If such concerns are present, the supervisor or caseworker will contact the hotline.

FY 2024 **Department Procedures should require placement staff to contact the placement clearance desk for a background check (i.e., CANTS/LEADS) when a child has self-selected an unauthorized placement (from Fiscal Year 2024 OIG Annual Report, General Investigation 3).**

2025 Department Update: In response to the OIG's recommendation, a multi-divisional workgroup was formed to review the identified concerns regarding unauthorized placements. The workgroup recommended numerous programmatic and policy changes as it relates to unauthorized placements. In addition, the Department's implementation of the KIND Act is in process which will impact the placement clearance desk and home of relative placements in general. Implementation will include changes to the placement clearance desk processing of relatives as well as acceptable background checks. The Department will no longer place youth with relatives who refuse to be fingerprinted, except in certain circumstances. The Procedures are being finalized and will be issued in December 2025.

FY 2024 **When placement staff are unable to gather enough information for placement clearance desk staff to conduct a background check for persons living with a youth in care in an unauthorized placement, due to the caretaker's refusal to cooperate, placement staff should be required to seek additional sources of information to complete the background check, such as, contacting local law enforcement, Integrated Eligibility System searches and Lexus Nexus searches (from Fiscal Year 2024 OIG Annual Report, General Investigation 3).**

2025 Department Update: In response to the OIG's recommendation, a multi-divisional workgroup was formed to review the identified concerns regarding unauthorized placements. The workgroup recommended numerous programmatic and policy changes as it relates to unauthorized placements. In addition, the Department's implementation of the KIND Act is in process which will impact the placement clearance desk and home of relative placements in general. Implementation will include changes to the placement clearance desk processing of relatives as well as acceptable background checks. The Department will no longer place youth with relatives who refuse to be fingerprinted, except in certain circumstances. The Procedures are being finalized and will be issued in December 2025.

FY 2024 **The Department should consider expanding the Human Trafficking Prevention Program through the creation of additional staff positions. The additional staff should be available to child protection staff to provide consultation when there are allegations of Human Trafficking of Children by Abuse (#40) or Human Trafficking of Children by Neglect (#90) (from Fiscal Year 2024 OIG Annual Report, General Investigation 3).**

2025 Department Update: The Department is in the process of expanding the Department's human trafficking division to include two human trafficking coordinators. There continues to be an on demand mandatory human trafficking specific training for all staff entitled, "Comprehensive Care for Trafficked Children." For the past three years the Department has contracted with The Power Project, to provide training to all congregate care facilities statewide. In January 2025 they provided a statewide virtual training for DCFS and CWCA staff. In June 2024, DCFS, Children's Advocacy Center (CAC), Department of Human Services (DHS), and the Illinois State Police (ISP) began a joint operation to strengthen the working relationship between these agencies as it relates to victims of Commercial Sexual Exploitation (CSEC). This began with the Interdiction for the Protection of Children training presented by the Texas Department of Public Safety. Staff from the previously mentioned agencies statewide participated in this two-day training. Also, two staff from each agency, including DCFS Training staff, participated in an extended training and were certified as trainers for the curriculum. The trainings are scheduled by ISP and are held at various locations across the state. DCFS, DHS, CAC, and ISP staff are the invited audience. DCFS, DHS, CAC and ISP collaborated and collectively submitted and received a three year 1.5-million-dollar grant from the Office for Victims of Crime (OVC). This grant has several deliverables which include universal training and screening tools for the state.

FY 2024 **This report should be shared with the Department's Medical Director, Director of Nursing and Director of Residential Monitoring to further explore the need for written policy and training for Department staff responsible for medication management and distribution when a child is brought in for an emergency shelter placement (from Fiscal Year 2024 OIG Annual Report, General Investigation 7).**

2025 Department Update: The Department issued guidelines for staff who volunteer for overtime shifts to support youth who are in a temporary setting awaiting placement.

FY 2024 **The Department's Office of Legal Services should provide training and guidance to child protection staff and intact family services staff on their options when encountering barriers when seeking court involvement including court ordered services and temporary custody. This guidance should include how DCFS attorneys can provide assistance to the field (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 6).**

2025 Department Update: The Office of Legal Services convened a workgroup to address how DCFS regional attorneys can support the field in filing a petition when the State's Attorney has declined to do so, including the possibility of whether and when DCFS would itself consider filing a petition. The workgroup clarified the ongoing collaboration between Deputy General Counsels statewide and child protection, and intact leadership, noting that these divisions meet regularly to address specific cases that present barriers to court involvement. The workgroup further clarified that DCFS will always consider filing a petition when appropriate to do so; however, that decision is made by the Assistant Deputy General Counsel and Deputy General Counsels for the region. The workgroup determined that if a State's Attorney declines to file a petition at the Department's urging, the Regional Administrator of the division (e.g. child protection) should review the case to assess the nature of the barriers to court involvement. As needed, the Regional Administrator should contact the regional Deputy General Counsel to consult about whether DCFS should pursue filing its own petition in a particular case.

FY 2024 **The Department should develop and maintain a tracking system for DCFS Nurse Referrals (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 2).**

2025 Department Update: The Clinical Division has made improvements on tracking the nursing referrals by implementing a tracking tool. This is an interim step while the full IllinoisConnect system is being built. The Nursing Referral, in the future, will become an electronic request through our IllinoisConnect applications that are being designed and developed. Once IllinoisConnect is live the application will meet the desired outcome of having an electronic Nursing Referral form in a system that can be tracked and reported on in future years. Currently, a tracking system is in place, and all referrals, both assigned and completed, are logged on a spreadsheet daily and totaled monthly. Referrals are tracked by the clerical staff overseeing the intake mailbox. The nursing division continues to provide ongoing education to each division. This includes the referral process and what to expect from nursing when they submit a referral to the nurse referral email box.

FY 2024 **The Director of Nursing services should collaborate with the Director of the Division of Specialized Care for Children to develop guidelines for appropriate referrals between the two agencies, including families involved with child protection investigations and intact family service cases (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 2).**

2025 Department Update: The Division of Specialized Care for Children (DSCC) leaders and DCFS Chief of Nursing Services will continue to meet to strengthen and streamline the referral process between the two agencies. DCFS Nursing will share updates regarding the DSCC referral process with the field.

FY 2024 **The Department should finalize and issue procedures for Child Welfare Services (CWS) Referrals. The procedures should require that in the event that a child protection investigation is initiated while a child welfare service referral is open, a staffing should be held with the CWS worker,**

the child protection investigator and their supervisors to discuss service needs for the family (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 1).

2025 Department Update: The recommendation has been incorporated into the draft of Procedure 302.381, Community Connection Services, section (e)(8). The Department is finalizing revisions to the draft procedures. The procedures will be released by the end of 2025.

FY 2024 **The Department should develop procedures and provide training to placement and intact family services staff on working with dually involved youth (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 3).**

2025 Department Update: Illinois Healthcare and Family Services (HFS) in collaboration with DCFS developed a virtual training on the HFS program, Pathways to Success, and the collaboration with DCFS. The training provides an overview of the program and how the program can assist placement and intact workers with care coordination for eligible youth that have serious complex behavioral health challenges. The Pathway to Success training is available in the DCFS Virtual Training Center. In addition, statewide reviews of intact cases using the Department of Quality Assurance's Quality Enhancement Support Team tool is occurring quarterly, with regularly scheduled regional meetings with both DCFS and CWCA intact staff and supervisors to review the data, provide feedback, and influence training and policy.

FY 2024 **The Department should partner with the Illinois Department of Human Services (DHS) to provide training to DCFS placement staff on servicing developmentally delayed youth preparing to transition to adulthood. The training should include information on the availability and requirements of DCFS's Transition to Adult Services (TAS) program and the guidance set forth in Procedures 302, Appendix N, Transition Planning for Wards with Developmental Disabilities (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 3).**

2025 Department Update: The Department's Transition to Adult Services (TAS) coordinator works in close collaboration with the DCFS Placement Division and DHS representatives weekly. This regular interaction ensures that all cases involving youth diagnosed with intellectual/developmental disabilities on the DCFS transition list are reviewed, and the transition to DHS Adult Services is smooth. In partnership with the DCFS Guardian's Office and Diversified Services Network, the TAS Coordinator also conducts four annual training sessions open for all staff to attend, including Department and CWCA staff. Training topics include reviewing the TAS process, from DCFS Procedure 302, Appendix N, Transition to Adult Services; obtaining an adult guardian; and how to transition to adult Medicaid. Additional training is available upon request. Coordinators will also discuss topics during the clinical presentation with the field. Youth are identified by the submission of the CFS 418-L and supporting documentation to the Transition to Adulthood Services (TAS) Coordinator. Upon review of the referral packet, the TAS Coordinator will request additional information and/or schedule a meeting with the referring team to determine if the youth in care should be placed on the transition list. Additional information can be found in Procedure 302, Appendix N." The TAS coordinator and Intellectual and Developmental Disability (IDD) Statewide Administrator have begun the process of implementing a plan to identify IDD youth starting at age 14.5 in order to ensure that the process of acquiring all required documentation and assessments is started prior to age 17.5 in order to streamline the process once a youth turns 17.5.

FY 2024 **The Department should explore how child protection and intact family services staff can recognize and intervene when a family has a significant history with the Department and develop a plan to guide staff on the use of a family's history to identify, assess and intervene. The plan should inform training needs and procedural changes that address this issue (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 6).**

2025 Department Update: Procedures 300.50(a)(2), Pre-Commencement Activities for the Child Protection Specialist, instructs child protection staff to conduct a complete prior history search of all subjects

of the report; analyze the information found; identify risks; and based on the Situation, Background and Assessment, make a Recommendation for next steps to ensure child safety. Revisions to Procedure 300.50 and Procedure 302.388, Intact Family Services are in process.

FY 2024 **The Department should provide training to all frontline staff on teenage mental health and suicide. The training should include the need for timely assessment and intervention for this vulnerable population. (from Fiscal Year 2024 OIG Annual Report, Death and Serious Injury Investigation 8).**

2025 Department Update: The Clinical Division and Child Protection leadership met in August 2024 to discuss areas surrounding teenage mental health and suicide in order to develop a training for frontline staff. The training entitled, Teen Mental Health and Suicide, can be found online in the DCFS Virtual Training Center.

FY 2024 **The Department should develop a mechanism for identifying youth during child protection investigations and intact family services cases that also have delinquency involvement. The Department should ensure the sharing of information with appropriate court, probation, and community providers to better support case planning, reduce duplication of services, and increase the understanding of a youth's overall functioning and well-being (from Fiscal Year 2024 OIG Annual Report, General Investigation 10).**

2025 Department Update: Through the Children's Behavioral Health Initiative, the Department is connecting with other agencies and community partners to collaborate and communicate to obtain vital services for children and families. These discussions occur weekly which lead to avoidance of duplication of services and improved communication. Additionally, IllinoisConnect will have a legal section related to each child where intact workers and child protection staff can record all legal involvement.

FY 2023 **When a case is closed in court prior to the completion of the six months of required after care services in violation of Illinois law, the assigned caseworker and supervisor should contact the Office of Legal Services for assistance. OLS is encouraged to request the court to keep the case open during the six months of after care services. This recommendation should be incorporated in Procedures 315.250 and the Department should provide education to the field regarding this issue (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 7).**

2025 Department Update: The following language is being incorporated into Procedures 315.250(d)(11), "development of an After Care Case Plan in accordance with 705 ILCS 405/2-28(4)(b) which requires a family to cooperate with six months of after care services when a court restores youth to their parent's or guardian's custody or risk further court intervention. If the court does not order the parent(s) to cooperate with DCFS and comply with the terms of an aftercare plan or risk the loss of custody of the child and possible termination of parental rights, the placement worker or supervisor shall request such action by the Court. If the court still declines to order aftercare, the Regional Administrator or Program Manager over the placement team should review the case and contact the Assistant Deputy General Counsel in the region (in Cook County contact Deputy General Counsel) to discuss legal options for addressing the aftercare concern."

FY 2023 **The Department should collaborate with the Administrative Office of Illinois Courts (AOIC) to provide training and education on the procedural and statutory requirements of after care services to court personnel statewide. A redacted copy of this report should be shared with the AOIC and Office of Legal Services to assist with the training (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 7).**

2025 Department Update: The Office of Legal Services is collaborating with the Administrative Office of the Illinois Courts (AOIC) to present a one-hour continuing legal education (CLE) in early 2026, "Aftercare, Not Afterthought: Bench Basics & Best Practices for Monitoring Required Aftercare Services after

Return-Home Orders." As part of the CLE, participants will review statutory requirements (Juvenile Court Act, Children and Family Services Act, Ta'Naja's Law), examine case outcomes where aftercare was not implemented, and discuss strategies for strengthening court oversight and enforcement. The CLE will be open to judges, assistant state's attorneys, parent's attorneys, guardians *ad litem*, and DCFS attorneys.

FY 2023 **The Office of Legal Services should convene meetings with local State's Attorneys to discuss the procedural and statutory requirements of after care services (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 7).**

2025 Department Update: The Office of Legal Services is collaborating with the Administrative Office of the Illinois Courts (AOIC) to present a one-hour continuing legal education (CLE) in early 2026, "Aftercare, Not Afterthought: Bench Basics & Best Practices for Monitoring Required Aftercare Services after Return-Home Orders." As part of the CLE, participants will review statutory requirements (Juvenile Court Act, Children and Family Services Act, Ta'Naja's Law), examine case outcomes where aftercare was not implemented, and discuss strategies for strengthening court oversight and enforcement. The CLE will be open to judges, assistant state's attorneys, parent's attorneys, guardians *ad litem*, and DCFS attorneys. In addition, the Office of Legal Services and the Permanency Division developed a fact sheet about the requirements for after care services, including illustrative case examples, that will be shared with the CLE training materials and distributed more widely.

FY 2023 **A redacted copy of the report should be shared with the Department and incorporated in outreach and education regarding ethical decision making for supervisors and managers (from Fiscal Year 2023 OIG Annual Report, General Investigation 9).**

2025 Department Update: The Ethics Officer developed information for the Employee Handbook outlining ethical guidance for supervisory and staff relationships, which is under review by the General Counsel. The guidance incorporates ethical responsibilities of supervisors and staff, as well as ethical practice in client engagement.

FY 2023 **The Department should develop a policy addressing toxicology results detailing guidelines for accepted providers, inconclusive results and testing timeframes to be used by frontline staff (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 8).**

2025 Department Update: The recommendation will be incorporated in revisions to Procedure 302, Appendix A, Substance Affected Families. The revisions will reflect current practice and terminology. Relevant forms will also be revised and once updated will be easily accessible to staff.

FY 2022 **The Department should develop procedures for monitoring unauthorized placements. The procedures should include frequency of required home visits, contact with school and other service providers and GAL notification requirements. For youth in care under the age of 17, procedures should require a minimum of three visits per month (from January 2023 OIG Annual Report, General Investigation 2).**

2025 Department Update: In response to the recommendation, a multi-divisional workgroup was formed to review the identified concerns regarding unauthorized placements. The workgroup recommended numerous programmatic and policy changes as it relates to unauthorized placements. In addition, the Department's implementation of the KIND Act is in process which will impact the placement clearance desk and home of relative placements. Implementation will include changes to the placement clearance desk's processing of relatives as well as acceptable background checks. The procedural changes are in the process of being finalized.

FY 2022 **Any unauthorized placements for youth in care under the age of 17 and that last more than one month should be referred for a Clinical Intervention Placement Preservation staffing (from January 2023 OIG Annual Report, General Investigation 2).**

2025 Department Update: In response to the recommendation, a multi-divisional workgroup was formed to review the identified concerns regarding unauthorized placements. The workgroup recommended numerous programmatic and policy changes as it relates to unauthorized placements. In addition, the Department's implementation of the KIND Act is in process which will impact the placement clearance desk and home of relative placements. Implementation will include changes to the placement clearance desk's processing of relatives as well as acceptable background checks. The Procedures are being finalized and will be issued in December 2025.

FY 2022 **The Department should develop procedures to ensure youth in care who are placed in a private institution, not contracted with the Department, receive a monthly stipend for basic goods and necessities (from January 2023 OIG Annual Report, General Investigation 4).**

2025 Department Update: The Department will develop a process to address the recommendation.

FY 2022 **The Department's Division of Clinical Practice's Behavioral Health Substance Use Group should use this report for the development of an informational reference guide for staff on recognizing signs of client substance misuse. The reference guide should also include information for both professionals and non-professionals in a supervisory role during parent-child visitation (from January 2023 OIG Annual Report, General Investigation 5).**

2025 Department Update: The recommendation will be incorporated in revisions to Procedure 302, Appendix A, Substance Affected Families. The revisions will reflect current practice and terminology. Relevant forms will also be revised and once updated will be easily accessible to staff. In addition, educational tip sheets outlining how to recognize signs of client substance misuse were announced and posted on the D-net. The tip sheets can be found on the Clinical Division's page on the D-net.

FY 2022 **This report should be shared with the Division of Clinical Practice Behavioral Health/ Substance Use group. The group should develop guidelines around assessment of marijuana use and its impact on parenting (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 1).**

2025 Department Update The recommendation will be incorporated in revisions to Procedure 302, Appendix A, Substance Affected Families. The revisions will reflect current practice and terminology. Relevant forms will also be revised and once updated will be easily accessible to staff. In addition, educational tip sheets outlining how to recognize signs of client substance misuse were announced and posted on the D-net. The tip sheets can be found on the Clinical Division's page on the D-net.

FY 2019 **The Department should create clear procedures for workers to have when confronted with an issue pertaining to the ever-growing field of electronic access to school records, particularly when the Department has custody and guardianship of a minor. Caseworkers should have clear direction as to when it would be appropriate to request a non-custodial parent's access be denied or restricted to school records. Further, the Department should determine whether caseworkers should request that the access be restricted from the school or through a court order. This should be developed in consultation with school districts and/or the Illinois State Board of Education (from January 2020 OIG Annual Report, General Investigation 13).**

2025 Department Update: The recommendation was incorporated in Information Transmittal 2025.11, Access to a Youth in Care's School Information and Records. The Information Transmittal was issued on November 14, 2025.

FY 2024 **The Department should explore the feasibility of electronic storage of attachments to child protection investigations, such as medical records obtained during the investigation, in the Department's new child welfare data system, IllinoisConnect (from Fiscal Year 2024 OIG Annual Report, General Investigation 2).**

2025 Department Update: IllinoisConnect will support the storage of all media types (documents, photos, video, and audio). Implementation within IllinoisConnect will occur in 2026.

FY 2024 **The OIG reiterates the following prior OIG recommendation, "The Department should ensure that the intact referral process is incorporated into the Department's new data information system to allow for tracking, follow-up, and initiation of services." (from Fiscal Year 2024 OIG Annual Report, General Investigation 8).**

2025 Department Update: This process will be fully incorporated into the IllinoisConnect system and will allow for an automatic referral and case opening process.

FY 2024 **While awaiting implementation of the Department's new data information system, the Department should develop an interim measure that ensures better checks and balances within the current intact family services referral process. These interim measures should include a requirement that the child protection investigator document in a SACWIS case note the date and time the CFS 2040, Intact Family Services Case Referral and Assignment Form was emailed to their supervisor (from Fiscal Year 2024 OIG Annual Report, General Investigation 8).**

2025 Department Update: The Division of Child Protection agrees to requiring the child protection investigator document in a SACWIS case note the date and time the CFS 2040, Intact Family Services Case Referral and Assignment Form was emailed to their supervisor as an interim measure until the full development and transition to IllinoisConnect. Also, the Deputy Director of Child Protection and Deputy Director of Intact Family Services will continue their standing monthly meeting to review data regarding potential delays of intact case opening, intact refusal data, and referral documentation.

FY 2024 **The Department's new data information system, IllinoisConnect, should require approval of the area administrator in cases of an alleged child victim (ACV) 0-3 as a mandatory field that cannot be waived by a child protection supervisor (from Fiscal Year 2023 OIG Annual Report, General Investigation 4).**

2025 Department Update: The recommendation will be incorporated in IllinoisConnect.

FY 2023 **The Department must secure a mobile application for child protection and other DCFS and private agency staff to use for on-demand video for American Sign Language interpretation services (from Fiscal Year 2023 OIG Annual Report, General Investigation 4).**

2025 Department Update: The developers of the ASK app are exploring the feasibility of an application that allows staff to use on-demand video for American Sign Language interpretation.

FY 2023 **The Department should explore technology that provides real time information for better oversight and coordination for child protection supervisors to ensure children are being seen in a timely manner. This data should allow for a distinction between when a child is physically seen and when a good faith attempt was made but the child was not seen (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 2).**

2025 Department Update: The Division of Child Protection and the Department of Information and Technology (DoIT) are committed to exploring technology with the ongoing development of IllinoisConnect that will provide greater oversight and coordination for child protection supervisors. This technology

will enhance current data provided through PowerBI, which provides a distinction between victims seen and documented and victims not seen and/or documented.

FY 2023 **The Department's new data system, IllinoisConnect, should include prompts for required investigative contacts that cannot be waived and prompts when a waiver is required (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 1).**

2025 Department Update: The Department will include required investigative contacts that cannot be waived and prompting when a waiver is required, in ongoing discussions in the development of the Department's new data system, IllinoisConnect.

FY 2023 **The Department should develop and implement a means to maintain electronic records of all consents approved by the DCFS Guardian in a youth in care's person management file in the Department's new data system, IllinoisConnect or SACWIS (from Fiscal Year 2023 OIG Annual Report, General Investigation 5).**

2025 Department Update: Staff from the Office of the Guardian met with the IllinoisConnect development team and requested that the new data system allow for all consents to be transported to youth in care's electronic casefiles.

FY 2022 **The Department's new data information system should include a mechanism for direct notification to licensing of a child protection investigation involving a facility (from January 2023 OIG Annual Report, General Investigation 6).**

2025 Department Update: In FY 2022, at Child Protection statewide meetings for supervisors and area administrators, the need for child protection to notify licensing at the onset of any facility report, licensed or unlicensed, was emphasized. In addition, automation of notifications, including to licensing, will be a part of ongoing discussions and requests as the Department moves forward with the development of Release 8 of IllinoisConnect. The targeted implementation date is FY 2026.

FY 2021 **There should be an automatic electronic notification process to notify the Area Administrator where there is physical abuse to a child under 3, and the Area Administrator must review the case prior to closure (from January 2022 OIG Annual Report, Death and Serious Injury Investigation 3).**

2025 Department Update: The IllinoisConnect project began July 1, 2022. Notification through several channels (email, screen popups, text messages, Microsoft Teams messages, etc.) are a base capability of IllinoisConnect. IllinoisConnect also contains workflows as a base capability which will be used to trigger the required review by an Area Administrator. In the meantime, the Area Administrators get a weekly report of child protection investigations involving children under the age of 3 and are required, per procedure, to document their assessment at the time of the safety decision.

FY 2020 **DCFS should ensure that the new data information system (IllinoisConnect) has an indicator to alert SCR staff when a subject in a Hotline report has had their parental rights terminated. (from January 2021 OIG Annual Report, General Investigation 2).**

2025 Department Update: The Department will ensure there is an indicator to alert State Central Register staff when a subject in a Hotline report has had their parental rights terminated.

FY 2020 **With the development of the Department's new data information system, the Department should request that the system be able to track the CANTS and LEADS searches of individual users (from January 2021 OIG Annual Report, General Investigation 3).**

2025 Department Update: The IllinoisConnect project began July 1, 2022. Tracking and automation of CANTS and LEADS searches will be part of IllinoisConnect. The Department will ensure that the new system tracks CANTS and LEADS searches of individual users.

FY 2020 **The Department should ensure that SACWIS and/or the Department's new data information system has the prior history of individuals linked to that person and accessible from clicking on the person's name (from January 2021 OIG Annual Report, General Investigation 4).**

2025 Department Update: The recommendation will be incorporated in IllinoisConnect. IllinoisConnect will have significantly improved relationship linking of individuals of intakes and full access to person histories with DCFS. IllinoisConnect will provide this same capability to case management functions.

FY 2019 **The SACWIS version of the Adult Substance Abuse Screen should be amended so that the collateral section cannot be bypassed without a waiver. The waiver should only be given if there is no indication of substance abuse (from January 2020 OIG Annual Report, General Investigation 6).**

2025 Department Update: The recommendation will be incorporated in the IllinoisConnect project. The IllinoisConnect project began July 1, 2022. As part of the implementation of IllinoisConnect, all forms are being reviewed and processes optimized.

GLOSSARY

AA: Area Administrator
ACV: Alleged child victim
AHU: Administrative Hearings Unit
ALJ: Administrative Law Judge
ANCRA: Abused and Neglected Child Reporting Act
AOIC: Administrative Office of Illinois Courts
APME: Agency Performance Monitoring and Execution
CAC: Children's Advocacy Center
CANTS/LEADS: Child Abuse and Neglect Tracking System/ Law Enforcement Agencies Data System
CDRT: Child Death Review Team
CERAP: Child Endangerment Risk Assessment Protocol
CLE: Continuing Legal Education
CMS: Illinois Central Management Services
CPAS: Child Protection Advanced Specialist
CPS: Child Protection Specialist
CPTA: Child Protection Training Academy
CSEC: Commercial sexual exploitation of children
CWCA: Child Welfare Contributing Agencies
CWEL: Child Welfare Employee Licensure
CWS: Child Welfare Specialist or Child Welfare Services
DCFS: Illinois Department of Children and Family Services
DCP: Division of Child Protection
DHS: Illinois Department of Human Services
DSCC: Division of Specialized Care for Children
DJJ: Illinois Department of Juvenile Justice
DoIT: Illinois Division of Innovation and Technology
EFSP: Extended Family Support Program
ELRT: Emergency Licensing Review Team
ERT: Error Reduction Training
FBI: Federal Bureau of Investigations
FY: Fiscal Year
GAL: Guardian *ad litem*
HFS: Illinois Department of Healthcare and Family Services
IA: Integrated Assessment
IDD: Intellectual and Developmental Disability
IG: Inspector General
ILCS: Illinois Complied Statutes
ILO: Independent Living Option
IMSA: Information Management System
IO: Information Only
ISP: Illinois State Police
LEADS: Law Enforcement Agencies Data System
MPEEC: Multidisciplinary Pediatric Education and Evaluation Consortium
OCWEL: Office of Child Welfare Employee Licensure
OEIG: Illinois Office of the Executive Inspector General
OES: Office of Employee Services
OIG: Office of the Inspector General
OLPD: Office of Learning and Professional Development

OLS: Office of Legal Services
OVC: Office for Victims of Crimes
PPP: Payment Protection Program
SACWIS: Statewide Automated Child Welfare Information System
SAFE Model: Safety Assessment and Family Evaluation (SAFE) Model
SCR: Illinois State Central Register
TA: Temporary Assigned
TAS: Transition to Adulthood Services
TLP: Transitional Living Program
UIS: University of Illinois at Springfield
YIC: Youth in Care