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

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

Pursuant to 20 ILCS 505/35.5

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LETTER FROM THE INSPECTOR GENERAL

To the Governor and Members of the General Assembly:

Recently, I had a difficult conversation with a child advocate that went as follows: "Are you saying that the child protection training caused this child's death?" "No", I responded, "what I mean to say is our investigation into this child's death found a complex picture of the truth-- this child's life was needlessly taken". We cannot avoid this complexity-we serve burdened parents who may forego their duty to protect their children. One of this office's legislative assignments is to examine the difficulties of our child welfare failures. In the appendix of this year's legislative report are redacted investigations on the deaths of two children, one an infant and the second, an eight year-old youngster.

By honestly looking at our failures we attempt to prevent future harms. We have to accept the reality, as the moral philosopher Jerome Wakefield reminds us, that some parents may compromise their children because of personal desires that are stronger than their desire to parent. The desire for personal freedom, adult companionship, drugs or alcohol may override their duty to their children. In such circumstances, the parents' rights over their children may be temporarily limited. Meeting parental duty to children is the fundamental basis for a parent's right to their children. A compromise in this parental duty may result in a corresponding compromise to a right, such as the right to privacy. In child welfare cases the threat of harm or a substantiated incident of harm to a child makes the privacy of the parent secondary to the good of the child. It is not a comfortable circumstance for either the parent or the child welfare worker.

In the above families' circumstances, the mother and the father in one case, and the mother and boyfriend in the second case, had viable family members who, if asked, would have assisted child welfare in protecting the children during the investigation and throughout intact family services while the parents ironed out their problems. In the one case relatives were not asked to help develop a protective day care plan for an infant. When a relative visited the infant and found a suspicious bruise she attempted, to no avail, to elicit a reasonable response from the intact family service providers and the local child protection investigator. In the second case, no relatives were contacted during an abuse investigation. The relatives lived in the same community and had in the past a caring relationship with the child. The extended family also had strong concerns about the mother's current boyfriend. However, the extended family members were seen as extraneous to the children's circumstances. The fact that the parent did not "get along with them" was viewed as sufficient reason for child welfare not to pursue the extended families' involvement.

A misconception of the parent's right to privacy appeared to be the fault-line dividing these children from protective relatives. Because of this misconception generations of two families' histories have tragic legacies with murdered children. The complex truth is each of our children belongs to a larger legacy of generations within families that should not be overshadowed by wanton desires or child welfare errors.

> *At this center we set this seed, this flower, whose genealogy we suggested and whose context in eternal history, his royalty, his miraculousness his great potentiality: we try at least to suggest also his incomparable tenderness to experience, his malleability, the almost inimaginable nakedness and defensivelessness of fivewindowed nerve and core. At this center we set this seed, this flower, whose genealogy we have suggested the size, the pity, the abomination of the crimes he is to sustain, against the incredible sweetness, strength, and beauty of what he might be and is cheated of.*
>
> James Agee - *Let Us now Praise Famous Men.*

Respectfully,

Denise Kane

INTRODUCTION

I. THE OFFICE OF THE INSPECTOR GENERAL (OIG)

The position of Inspector General was created by unanimous vote of the Illinois General Assembly in June 1993 to do more to reform the child welfare system and to strengthen the people who exist within it: DCFS employees, foster parents, private agencies, and most important the children and their families. The mandate of the OIG is to investigate misconduct, misfeasance, malfeasance, and violations of rules, procedures, or laws by Department of Children and Family Services employees, foster parents, service providers and contractors with the Department. To that end, this Office has undertaken numerous investigations and initiated projects designed to uncover wrongdoing, improve practice and professionalize the Department. The value and focus of the OIG is the individual life of the child. The Office responds to and investigates complaints filed by the state and local judiciary, foster parents, biological parents and the general public. Additionally, the OIG investigates deaths of all Illinois children with whom DCFS had prior involvement within the preceding twelve months. At the request of the Director or when the OIG has noticed a particularly high level of complaints in a specific segment of the child welfare system, the OIG will conduct a systemic review of that segment. Investigations yield both case-specific recommendations and recommendations for systemic changes within the child welfare system. The OIG monitors compliance with all recommendations.

II. OIG INVESTIGATIVE PROCESS

The OIG had 1,114 requests for investigation in FY 00, 701 of which were requests for technical assistance. In addition, the OIG received 102 notices of child deaths.

The OIG investigative process begins when the State Central Register notifies the OIG of a child's death or when a Request for Investigation is filed with the Office. In FY 99, the OIG also began to review reports of serious injury. Complaints and death or serious injury investigations are screened to determine whether the facts suggest possible misconduct by a DCFS employee or private agency employee, or the need for systemic change. If a complaint is accepted for full investigation, the OIG will fully review records and interview relevant witnesses. When the investigation is completed, the OIG reports to the Director of DCFS and the Governor, with recommendations for discipline, systemic changes, or sanctions against private agencies. The OIG monitors the implementation of accepted recommendations. When recommendations focus on a private agency, the OIG may work directly with the agency and its board of directors to ensure implementation of the recommendations.

Requests for investigation can lead to a full investigation, a partial investigation, technical assistance, referral to other resource, or closure without investigation.

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

If a complaint is not appropriate for full investigation by the OIG, the OIG may refer the complaint to law enforcement (if possible criminal acts were committed); the DCFS Advocacy Office for Children and Families; or other state agencies such as the Department of Professional Regulation.

Confidentiality

A complainant to the OIG, or anyone providing information, may request that his or her identity be concealed from anyone outside the Office of the Inspector General until the investigation is concluded. Both 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 employee or private agency subject of an OIG report may review the Report (with confidential information deleted) and respond to any factual inaccuracies prior to the imposition of any discipline or sanction. In rare circumstances, however, the Inspector General may request that an agency be put on "hold" status or that an employee be placed on "desk duty" pending the outcome of an OIG investigation, when the allegations are sufficiently serious to present a risk to children. OIG Reports contain various types of information that is confidential pursuant to both state and federal law. As such, OIG Reports are not subject to the Freedom of Information Act. The OIG has prepared several reports with confidential information deleted, for use as teaching tools for private agency or Department employees.

Impounding

The OIG is charged with investigating misconduct "in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution." To conduct thorough investigations, investigators often must impound files to ensure the integrity of records. Impounding involves the immediate securing and retrieval of original Department or private agency records by the OIG. When files are impounded, the investigator leaves a receipt for impounded files with the office or agency. Important information may be copied by the worker during the impound in the presence of the investigator. Impounded files are returned as soon as practicable.

File Return Policy

When the Department transferred significant caseloads to private agencies in 1996, the Department did not retain copies of its files before transferring the files to private agencies. As a result, the OIG instituted a policy of making an additional copy of all files impounded in death investigations and returning originals to the DCFS Division of Legal Services to ensure that the Department maintains a central file for certain records.

Criminal Background Investigations

The OIG provides training and technical assistance to the Department and private agencies in performing criminal history checks. In FY 00, the OIG performed 3,709 searches for criminal background information from the Law Enforcement Agencies Database System (LEADS). In addition, in the course of an investigation, if evidence indicates that a criminal act may have been committed, the OIG may notify the Illinois State Police, Attorney General or other appropriate law enforcement agency or elect to investigate the alleged act for administrative action only. The OIG will assist the law enforcement agency with gathering necessary documents. If the law enforcement agency elects to investigate, the OIG will close that portion of the OIG case referred but retain the case on monitor status. If the law enforcement agency declines to prosecute, the OIG will determine if administrative action is appropriate.

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

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

The OIG uses certain reports as teaching/training tools. The reports are redacted to ensure confidentiality and then distributed to private agencies, the schools of social work, and DCFS libraries as a resource for child welfare professionals to provide prudent professionals a venue for an ethical discussion on individual and systemic problems within the practices of child welfare. While there is always the risk of unscrupulous exploitation from any admission of human or bureaucratic error, for knowledge to grow and outcomes to improve we need the honesty and truthfulness that can only occur with introspection. It is with the trust of ethical agencies and individuals who struggle with these issues in a fair and just way that we can have hope for the future of Illinois child welfare. It is only through the discipline of consistent virtuous actions that we obtain integrity. A packet of redacted OIG reports is available by contacting the OIG at (312) 433-3000.

Monitoring
The OIG monitors implementation of OIG recommendations. Monitoring may take several forms. The OIG may monitor to ensure that Department or private agency staff implement the recommendation or the OIG may work directly with the Department or private agency implementing recommendations, which call for systemic reform. In addition, the OIG may "incubate" accepted reform initiatives within the OIG for future integration into the Department. Recommendations made to private agencies are generally monitored directly by the OIG or by the OIG and a representative of the Department's Agency Performance Teams.

Death Review
The OIG investigates all cases in Illinois in which a child has died while a ward of DCFS, the subject of an open investigation or family case, or the subject of a closed abuse and neglect report or case within the last twelve months. The OIG received notification from the State Central Register (SCR) of 102 child deaths in FY 00. Death investigations that resulted in major report recommendations are included in the Investigations Section of this Report. The OIG is a member of Child Death Review teams around the state.

III. RECOMMENDATIONS

Through investigative reports, the OIG makes recommendations for both systemic reform and case specific responses. Systemic recommendations are designed to strengthen the child welfare system as a whole to better serve each child and family.

Ideally, discipline should be constructive in the sense that it serves to educate an employee on matters related to his/her misconduct. However, it must be more than an educational opportunity. It must also function to hold employees responsible for their conduct. Hence, discipline should have an accountability component as well as a constructive or didactic one. Without the accountability component, there is little

to deter misconduct. Without the didactic component, an employee may conclude that s/he has simply violated an arbitrary rule with no rationale behind it.

Once a recommendation regarding discipline has been made, the OIG will present it to the Director of DCFS. If accepted, the Department will initiate disciplinary proceedings with the employee. The employee will have a chance to review the evidence and submit a response. After receiving the response, the Department will determine whether discipline is appropriate. If the Department determines discipline is appropriate, it will be administered and noted in the employee's personnel file. In addition, the OIG will determine whether the facts suggest a systemic problem or an isolated instance of misconduct or bad practice. If the facts suggest a systemic problem, the OIG may investigate further to determine appropriate recommendations for systemic reform.

The investigations for FY 00 are divided into two major categories: Death Investigations and General Investigations.

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

IV. OIG FOSTER PARENT HOTLINE

Pursuant to statute, the OIG operates a statewide, toll-free telephone number for foster parent access. Foster parents have called the hotline to request assistance in addressing the following concerns:

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

The Foster Parent Hotline received 722 calls in FY

In FY 00, the OIG Foster Parent Hotline received 722 calls. Of those, 622 calls were for information and referrals, 54 calls were referred to the SCR hotline, and 46 calls were referred to the OIG for investigation.

The Foster Parent Hotline is an effective tool that enables the OIG to: communicate with concerned persons; respond to the needs of foster children; and address the day-to-day problems that foster care providers often encounter.

Foster parents contact the OIG Foster Parent Hotline by calling (800) 722-9124

DEATH INVESTIGATIONS

Death Investigation 1

ALLEGATION An eight year-old boy was beaten to death over the course of three weeks by his mother's live-in boyfriend. The boy's mother was out of state at the time of his death but was thought to have knowledge of the ongoing abuse that led to his death. The boyfriend pled guilty to first-degree murder and is serving a life sentence. The mother is awaiting trial.

INVESTIGATION Prior to the boy's death, the mother and boyfriend were indicated for cuts, welts and bruises. At the time of the report, the boy told his teacher his injuries had been inflicted by his mother's boyfriend and was worried that if she told authorities he would get in trouble. The mother told the DCP investigator assigned to the case that her boyfriend had spanked the boy with a belt or extension cord for lying but she believed the punishment was too harsh and the couple agreed the boyfriend would not spank the boy with an instrument again. The investigator met with the boyfriend who said he spanked the boy because he lied about his homework. He told the investigator that he had acted with the boy's best interests in mind when he whipped him but acknowledged he went too far. He assured the investigator the boy would not suffer any repercussions as a result of the Department's involvement. The couple, who were staying in the home of a friend at the time, told the investigator they had recently moved to Illinois from out of state and had not had any previous involvement with child protection agencies. The boyfriend presented his Certified Nursing Assistant Registration Verification issued by the Illinois Department of Public Health which on its face appears to show that he had no child abuse or neglect charges against him. However, this certificate was limited to Illinois data and actually dealt specifically with abuse and neglect charges in public elderly care institutions. The boyfriend, who had previously lived in another state, had both indicated reports of abuse in that state and a criminal history of arrests for domestic violence. The DCP investigator suggested that the Department might be able to assist them in obtaining housing if they accepted services, a prospect the couple responded to positively.

The DCP investigator recommended indicating the case and referred it to follow-up services. The follow-up worker, in conjunction with a housing advocate, endeavored to locate a suitable residence for the family. The couple was also looking for housing and contacted the follow-up worker after they located an apartment they wanted. The follow-up worker's supervisor, concerned about the family's ability to afford the rent and the apartment's distance from their places of employment, denied their request for aid. The couple responded by claiming the Department had lied to them and stating they were no longer interested in accepting any services. They left their friend's home soon after and did not notify any involved workers of their whereabouts. The involved workers were eventually able to locate the family at their new home. The DCP investigator met with them and informed the couple the report would be indicated. The couple was still angry over the housing issue and refused any further services. The DCP investigator filled out a Family Assessment Factor Worksheet, listing the overall risk to the boy as low, and completed his investigation. The investigator did not interview the members of the household with whom the couple and their children were living. Staff at the boy's new school were not interviewed or informed of the history of abuse. The follow-up worker's supervisor instructed him to close the case because of the family's persistent rejection of any involvement with the Department.

After the boy's death it was discovered that the mother's boyfriend had previous indicated abuse reports in the state of Florida and a criminal history of domestic violence. The DCP investigator told the OIG he believed he could not perform out-of-state CANTS or LEADS checks on the couple without their consent.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **DCFS should amend policy and procedure to add a rule stating that the Department must make an independent inquiry of child abuse/neglect indications in other states when an adult member of the household has lived in other states within the last five years. Such an inquiry should be made whenever information is discovered that an adult household member has resided outside Illinois. If the follow-up division finds out such information, the DCP manager should be informed and ensure that such an inquiry is completed. The LEADS protocol currently requires that an out-of-state LEADS check be conducted whenever there is reason to suspect that a subject of a report has a criminal record outside of Illinois. DCP should always make an independent inquiry of CANTS and LEADS in Illinois (even if a certificate, license, or other document is presented that previously required such checks to be completed).**

The Department agreed. DCFS policy and procedure is currently being amended to require an independent inquiry of child abuse/neglect indications in other states when an adult member of the household has lived in other states in the last five years.

2. DCFS should not close cases, where there is an indicated finding of abuse, on the basis that the parents or caretakers will not cooperate with services. If the caretakers will not cooperate, DCFS needs to attempt to screen the case into court and continue to try to monitor the safety of the child(ren) while the court petition is being filed. Because of the caretakers' lack of cooperation, such monitoring may include attempts to visit the child in school, day care or other such settings. DCFS should fully document all attempts to contact the caretakers and provide services. If the State's Attorney's Office refuses to file, DCFS should document the reason(s) why and what further information the SAO states is necessary to file a petition.

The Department had implemented an interim policy on handling cases of physical abuse by paramours to provide additional safeguards for children involved in these types of investigations. The final policy was implemented August 15, 2000. Cases will no longer be closed where there is an indicated finding of abuse on the basis that the parents or caretakers will not cooperate with services., but will try to have these cases screened into court. The Department will develop guidelines that clarify when to screen those cases into court.

3. Child abuse and neglect is as much a public health issue as a social work issue. The Department of Children and Family Services first came into contact with this child after a teacher saw his bruises and called the hotline. Because the faculty and staff at the school were then aware of the abuse, they were able to be alert to further signs of abuse. When the boy moved to his new school, information about his past abuse did not follow him. Thus, faculty and staff in his new school were not on heightened alert for possible signs of abuse or excessive absences. To help protect other children in the future, the Department should work with the Illinois Department of Education and the Illinois Department of Public Health to have indicated abuse or neglect that was reported by school faculty or staff noted on a student's permanent health record that transfers with other school records when a child changes schools. This will inform the new school that the child has been a victim of abuse or neglect in the past and the staff, as mandated reporters, should be attentive to signs of abuse or neglect and excessive absences.

The Department agrees to explore the possibilities of implementing this recommendation with the Department of Education and the Department of Public Health.

4. The Illinois Department of Public Health (IDPH) issued a certificate to the mother's boyfriend that

indicated he had no indicated child abuse or neglect reports and no criminal convictions. The OIG requests permission to share this report with IDPH to discuss a change in the certificates to include a disclaimer for out of state safety checks.

The Department agreed.

The OIG met with IDPH. The IDPH agreed that its current form could be misread and agreed to revise it.

5. The DCP investigator should be disciplined for not doing a full investigation. He did not make any collateral contacts and did not interview all members of the household.

The DCP investigator's supervisor should be disciplined for signing off on an inadequate investigation.

The follow-up worker's supervisor should be disciplined for her decision to close a case based upon the parents' non-cooperation rather than an alleviation of risk factors.

The Department agreed. Due to inadvertent publicity, the Department and the OIG are in agreement that official disciplinary action will not be pursued. However, the report has been discussed with involved staff and the Department has provided intensive management oversight and implemented corrective measures.

6. DCFS should advise supervisors that whenever legitimate casework or clinical concerns dictate sharing information, but it appears that concerns over confidentiality do not allow such sharing, the supervisor must contact DCFS Legal, who will document both the call and the answer given to the supervisor. The OIG would like to monitor these calls as part of a continuing investigation of casework confidentiality issues.

The Department agreed. The Office of Legal Services will document all calls regarding confidentiality concerns raised by staff.

7. The OIG concurs with the recommendations submitted to the Director from the Child Death Review Team.

The Department also concurs with the recommendations made by the Death Review Team and will be implementing those recommendations.

8. The OIG requests permission to share a redacted copy of this report with the agency that develops child protection training materials.

The Department agreed.

The OIG shared a copy of the report with the agency.

Death Investigation 2

ALLEGATION A five month-old boy died as a result of internal bleeding caused by blunt trauma to the abdomen and head. The infant's father was convicted of first-degree murder. The OIG investigated this child's death because his family had an intact family case open at the time of his death.

INVESTIGATION A hotline call was made after the father brought the child into the mother's office one day and one of her co-worker's observed that the infant had two black eyes. The Division of Child Protection investigator assigned to the case interviewed the mother's co-workers who stated it was "common knowledge" she was physically abused by her boyfriend. They also suspected the father abused the child because they had previously seen bruises on the boy and heard statements by the mother that the father tied him to his crib. The DCP investigator asked local police to go to the home that evening to check on the child and went out himself to meet with the parents the next morning. In both instances the father was cooperative and appeared very concerned. He and the mother told the investigator that the black eyes were the result of a bathing accident, though the mother had not been home at the time. They explained the story of tying the boy to his crib was a simple joke that had been misinterpreted by her co-workers.

The investigator interviewed the couple's parents as well as teachers and students from the high school the couple had recently attended. All acknowledged the interracial couple had a stormy relationship, which was exacerbated by the Caucasian female's parent's dislike for the African-American father. The DCP investigator told the OIG that most of the interviewees, particularly the relatives, could have been influenced by bias. His supervisor pointed out to the OIG that the couple was living in a white community and that racial bias may have been a factor. The DCP investigator believed the only objective opinion was that of the child's doctor. The doctor said that child's injuries were consistent with the explanation provided and he felt the mother behaved appropriately when she brought the boy in for office appointments. The DCP investigator concluded that there was insufficient evidence to indicate the report for abuse. However the investigator was concerned about domestic violence in the home and wanted the family involved with services. The investigator determined he could only indicate the report for neglect based on the father's admission to another accident caused by his lack of supervision that resulted in bruises on the child. The investigator, however, specifically noted the presence of violence issues in the home which needed to be addressed in follow-up. DCP referred the couple for family preservation services through a private agency that was expected to begin working with the family immediately. The agency was to work with the father who lacked parenting skills and make unscheduled visits to monitor violence in the home.

After the DCP investigator had completed his investigation, he received a call from the maternal grandmother who stated she "thought" she had seen bruises on the baby's back. The investigator referred her to the private agency therapist who was then responsible for the case. When the grandmother told the therapist about the bruises, he conferred with his supervisor who instructed him to go to the home. Arriving unannounced, the therapist viewed the baby and saw bruises on the child's back, however the novice therapist was unsure whether such marks were signs of abuse or could have been caused in another manner. The therapist informed his supervisor who determined that there was nothing to warrant a hotline call. The supervisor was hesitant to accept the grandmother's report of bruises because he suspected that she was biased against the father. The therapist stated he was uneasy with this decision but deferred to his supervisor's judgment.

The next morning the therapist and his supervisor reconsidered the situation with other staff. They determined that bruises on the back of a five month-old infant could not be accidental. The supervisor instructed the therapist to ask the grandmother to call the hotline because it would be more likely that the hotline would accept a call from a primary witness. After several hours, the therapist reached the

grandmother by phone. She told the therapist she was uncomfortable about calling the hotline and asked that he make the hotline call.

Before calling, however, the therapist went to the home for a scheduled visit. The mother was not home and the father told the therapist their son was sleeping. Concerned about upsetting the father, the therapist did not insist on viewing the infant. After leaving the home, the therapist called the hotline and was told a DCP investigator would go out to the home the following morning. One hour later, the father called 911 to request medical attention for his son. The boy was taken to a local emergency room where he was pronounced dead on arrival.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **In a previous OIG investigation, the OIG recommended that the Department more clearly define criteria for cases that are appropriate for Family First or Intensive Family Preservation Services (IFPS). The screening criteria for all Intensive Family Preservation Services programs should be refined to ensure that only cases in which the following two questions can be answered in the affirmative would be accepted:**

   - **Is the identified problem(s) likely to be corrected (or assessed) within 28 days?**
   - **Can the safety of the child(ren) be reasonably assured during the 28 days?**

Protective measures that could be taken to "reasonably assure" the safety of the children during the 28 days should be specified. These should include protective day care and extended family protective caretaking plans.

The OIG continues to recommend that the criteria be more clearly defined and that the above recommendation be implemented.

The Department agreed. This recommendation will be incorporated into Best Practice. As a result of the recommendations in the previous OIG report, the Intensive Family Preservation programs in Cook County have been terminated.

2. The Department of Human Services (DHS) has a detailed and well-grounded protocol for working with families for whom domestic violence is an issue. The Department should adopt the DHS protocol for working with families for whom domestic violence is a factor.

The Department agreed. The Department is hiring an employee to work specifically on domestic violence issues. The DHS Domestic Violence Protocol will be modified for use by the Department.

3. The DCP investigator should be counseled for his failure, following the completion of his investigation, to proactively respond to the grandmother's reports of observing bruises on the infant.

The Department agreed. The employee was counseled on October 3, 2000. The Department issued a Policy clarifying the need for Department staff to call the hotline themselves when credible information is presented.

4. The private agency should review this report with the supervisor to address the failure to supervise an appropriate assessment and delivery of comprehensive case management, the failure to recognize the necessity of calling the State Central Register (SCR) and the failure to call SCR in this case.

The agency should counsel the therapist for:

- failing to recognize the necessity of calling SCR
- failing to call SCR in this case.

The Department agreed.

The Inspector General discussed this report with the agency's Executive Director and members of the Board of Directors. The agency agreed to review the report with the supervisor. The therapist is no longer employed by the agency.

5. The Executive Director and the Board of Directors of the agency should receive a copy of this report and conduct an internal review of the case. The Inspector General will meet with the Executive Director and Board to discuss the findings and recommendations of this report.

The Department agreed.

The Inspector General met with the agency's Executive Director and Board of Directors in August 2000.

Death Investigation 3

ALLEGATION

A three month-old baby born with Fetal Alcohol Syndrome (FAS) died of Sudden Infant Death Syndrome (SIDS). At the time of the child's birth, his mother, a chronic alcoholic, was a licensed relative foster parent of three children.

INVESTIGATION

Hospital staff who delivered the baby called the hotline to report that the mother's toxicology screen showed a high blood alcohol level. A DCP investigator was assigned to the case and began by interviewing the reporters. An attending resident who assisted with the birth told the investigator the baby, who was still in the hospital, did have FAS but was not receiving medication for withdrawal and would not require special care upon discharge. The investigator also spoke with the mother's attending physician at the hospital who stated that following the delivery, the mother was hallucinating and needed to be medicated to offset her severe symptoms of withdrawal. The doctor told the investigator the mother had come to the emergency room twice for alcohol-related health problems in the months before she delivered. Tests showed the mother's pancreas and liver had been damaged by years of alcohol abuse. Hospital staff urged the mother to enter in-patient treatment but the mother refused. The investigator then interviewed the mother's family including her father who had lived in the home for the past few years. The grandfather told the investigator that his daughter was an alcoholic and had been drinking excessively for 20 years. The grandfather told the investigator that he helped care for the foster children and his grandson because his daughter sometimes did not feel like waking up.

The investigator contacted the private agency that placed the foster children in the home and spoke with the supervisor responsible for handling the case. The supervisor told the investigator that the assigned caseworker, who was no longer handling the case, was unaware of the mother's alcoholism and that the mother had hidden her pregnancy from the caseworker who learned the mother was expecting only a few months before the baby was born. The investigator completed an Adult Substance Abuse Screen but omitted significant information. She told the OIG she did not answer "Yes" to the question asking whether the mother had ever given birth to a drug-exposed infant because the mother had, in fact, given birth to an *alcohol* exposed infant. She also neglected to fully answer questions regarding the mother's health and medical history despite being aware of her alcohol-related health issues, providing only the information the mother had specifically given her. The Department's follow-up worker told the investigator that it might be best to screen the case for custody of the mother's biological children due to her denial of her alcohol problem. The investigator's supervisor instructed her to contact the Department of Alcohol and Substance Abuse (DASA) regarding treatment options. The supervisor also spoke with a private agency outreach worker who reviewed the mother's history and recommended detox and extensive treatment. It was determined that if the mother consented to participate in treatment, the biological children would not have to be taken into custody. The mother agreed and was referred to the outreach agency for alcohol treatment. However the agency evaluator assigned to the mother never received abuse assessment forms from the Department or his own agency's outreach worker and relied on the mother's own report of her drinking to establish a treatment plan for her. The evaluator was aware that the mother had given birth to a baby with alcohol in his system but neglected to follow up on that information. As a result, the assessment of the extent of the mother's addiction was grossly underestimated.

According to the investigator's notes, she informed the private agency supervisor that the mother would be indicated for substance misuse and that the case would be referred for intact family services. However the supervisor claimed she knew only that the there was a pending investigation and was not aware of the indicated finding or the intact family referral until after the baby's death. The supervisor also stated that although she had heard rumors about the mother's high blood alcohol level at the time of birth, the investigator was unclear whether a diagnosis of FAS was ever made. A copy of the CANTS 21 document which is used to notify interested parties of a pending investigation was found in the investigator's file.

however there was no evidence to suggest that either the CANTS 21 form or a copy of the DCP investigation had ever been sent to the private agency. Both the investigator and the private agency supervisor failed to document many of their conversations, transmissions or attempted contacts with each other regarding information vital to making a determination about the mother's fitness.

The mother had originally been licensed through another private agency, however when that agency was closed by the Department, her case was transferred. The agency that was shut down had destroyed all of their files so no background information was available to the accepting agency. A review of the agency's licensing file on the mother showed that other than a walk through of the home no other pertinent information was compiled about the mother's health, history or previous foster parent training.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1.The Department has a fiduciary duty to send the complete DCP report to the appropriate parties; it cannot delegate away its responsibility in this matter. The investigator's work on this case and her supervisor's lack of guidance indicate a poor understanding of the Substance Abuse Screen and a lack of thoroughness in complying with DCFS Rules and Procedures. They should be reprimanded for their failure to do the following:

a) ensure that the Substance Abuse Screen was complete and sent to the provider;
b) ensure that the CANTS 21 notices had been sent to the appropriate people; and
c) ensure that a copy of the DCP file had been sent to the appropriate people.

An OIG consultant should work with the DCP supervisor and her team to ensure they have a thorough understanding of SEI protocol. In addition, the Child Death Investigator for the Cook County Medical Examiner should discuss with the supervisor's team the Back to Sleep protocol and the dangers of overlay in families where substance abuse is an issue.

The Department agreed. The investigator was counseled on August 15, 2000. Appropriate discipline for the supervisor is pending.

2. The OIG recommends that the private agency review and discuss this report with the supervisor. Even if she did not know the case had been indicated, she still had concerns regarding the accuracy of the information given to the agency by the DCP investigator. In spite of this, the supervisor failed to confirm the information by contacting the appropriate people and continued to "work under the presumption that the case had been closed and unfounded." In addition, although she recognized the need to more carefully monitor the foster home, the supervisor failed to ensure that such monitoring occurred.

The Department agreed. The OIG agreed to go discuss the findings and recommendations in this report with the private agency.

The private agency received a copy of the report, reviewed it, and discussed it with the supervisor.

3. The private agency should receive a copy of this report. The OIG will meet with the Executive Director of the agency and the Board to discuss the findings and recommendation of the report.

The Department agreed.

The Inspector General met with the agency's President and members of the Board of Directors in September, 2000.

4. All agencies that have received cases from closed agencies must review their licensing files to determine if the appropriate documentation required for licensure is contained in the file. This documentation should include the following:

a) a new application;
b) family home information sheet;
c) copy of the Individual Licensing Summary (ILS);
d) medical report;
e) evidence that a new site visit has occurred and that the home is still in compliance – 590-document compliance record;
f) references; and
g) certificate of foster parent training. LEADS and CANTS information should have already have been verified by the Licensing Department.

In the event any of this information is not contained in the licensing file, the agency shall ensure that it is completed within 60 days. If there is no medical report in the file and the foster parent is unable to verify the necessary medical information, the Department shall pay for a new one. If there is no certificate of foster parent training, the agency may be able to verify that the foster parent has completed the required training by contacting the DCFS Office of Employee Instruction (formerly Child Welfare Training Institute). The DCFS Licensing Department should monitor this process.

The Department agreed. Policy will be sent to all private agencies and independent living programs regarding this recommendation.

5. The Project Manager of SACWIS should ensure that the CANTS 21 notice is clarified to state that the DCP investigator must send a copy of the indicated investigation to the assigned caseworkers/case managers of the other wards in the foster home or relative home placement and that problems regarding transmittal of the CANTS 21 notices are addressed.

The Department agreed. The CANTS 21 is currently under revision and this recommendation will be incorporated into those revisions.

6. The outreach worker's agency should be made aware of the deficiencies in its system of relaying information from the field to the assessment staff. The OIG sent a letter to the president of the agency outlining OIG concerns and recommending the following: 1) that the agency require that DCFS fax prior to the client's initial assessment the following three completed referral forms: a) Adult Substance Abuse Screen; b) DCFS Referral for Adult Alcohol and Other Drug Treatment Services; and c) Consent for Disclosure; and 2) that the agency ensure that its community outreach worker provide the agency's assessor with complete documentation of the client's history prior to meeting the client.

The Department agreed. The OIG agreed to take the lead on this recommendation and have sent a letter to the Executive Director of the outreach worker's agency.

7. The Department should place the home of the mother, who has two indicated reports for substance abuse, on hold. In addition, the private agency that licensed her should complete an investigation to determine if the mother's license should be revoked.

The Department agreed. The mother's home was put on hold May 30, 2000. The private agency that licensed the mother will conduct an investigation on the mother's home.

Death Investigation 4

ALLEGATION

An autopsy report issued by the medical examiner in the case of a seven year-old girl who died in May of 1999 stated that she, "died of asphyxia due to obstruction of the upper airway which occurred as a consequence of enlarged tonsils and adenoids" and that "obesity is considered a significant condition contributing to her death." At the time of the girl's death she was part of an intact family case serviced through a private agency.

INVESTIGATION

The family, comprised of three young girls, a baby boy and their mother, initially became involved with DCFS in June 1995 when a call was made to the hotline alleging that the mother hit the children and left them alone with their grandparents who were unable to care for them. The report was indicated for inadequate supervision and the case was opened as an intact family case with a private agency. The mother completed a parent-training course and demonstrated parenting skills to the worker during her home visits. Although the mother provided the case manager with some medical records, it was noted by the Department's Intact Family Service Monitor that the two oldest girls were still in need of some shots and there was no immunization record for the youngest daughter. The Department continued to request information from the agency regarding medical records and updated immunizations. There is, however, nothing in the file indicating that this information was obtained prior to the time the case was closed in May 1996.

The case was reopened in October 1998 following another hotline call. The report was indicated and the Department transferred the case to a different private agency. At the time, the two oldest daughters were not enrolled in school and immunization records for all three were either missing or incomplete. The assigned worker observed the mother to be a caring parent and responsible caretaker and believed she was trustworthy. The worker informed the mother of the importance of securing school enrollments and providing documentation of the children's medical records but accepted the mother's assurances that she would handle these tasks herself. Though the worker was diligent in contacting the mother, visiting the home and documenting contact, she continued to allow the mother to resist any assistance from the worker or her supervisor to secure school placements or proof of immunizations. The mother also rejected all requests for her to sign consent forms releasing the children's medical records to the agency. Although a consent for release of medical records had been obtained during the DCP investigation, it expired prior to the case being accepted by the caseworker. As time passed without these requirements being met, the mother's explanations became more elaborate and she argued adamantly for her right and ability to handle the situation herself. The caseworker and her supervisor interpreted this posture as a demonstration of the mother's pride and continually relented only to later find that no progress had been made as the intact family case remained open.

In an interview with the caseworker, the OIG learned that the she had contacted the children's pediatrician at the outset of the case. The doctor informed the caseworker as to the state of the children's immunizations and told her he had been seeing the oldest girl on a relatively frequent basis. The caseworker had observed the eldest daughter to be obese and the mother reported that she experienced some difficulty breathing due to asthma, but there did not appear to be any extraordinary circumstances. An OIG review of the girl's medical records showed no concern on the part of the child's doctors regarding her weight or respiratory condition.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **Immunization issue - The Department should prepare a memorandum to be distributed to all child protection workers emphasizing the importance of the immunization rule and the need to enforce it. When parents are unable to provide proof of immunization, investigators should give them thirty days to comply. If investigators do not receive verification of immunizations, the case should be indicated for medical neglect. Investigators can use the attached immunization schedule for verification. Investigators, intact, and follow up workers should be aware of**

and encouraged to work with their local Departments of Public Health programs for immunizations. In Chicago, parents can access Department of Public Health CareVans that travel daily to different sites in the city; in addition, Public Health Nurses may be available to make home visits.

The Department agreed that immunizations for children are vitally important. The Department's Division of Health Policy and Child Protection are collaborating in an effort to address the OIG's concerns.

2. Investigators should have parents sign consents for release of medical and school information that will be valid for at least six months. Consents should be to DCFS and contracting agencies. The OIG recommends that the Consent For Release of Information, previously submitted to the Department as a recommendation from the Mental Health Confidentiality Task Force, be adopted for use by all DCP investigators, intact, and follow-up workers.

The Department agreed. This recommendation will be incorporated into the revisions to Rule 431.

3. The Department's Chief of Nursing Services should meet with the supervisors of intact family units to discuss health and compliance issues among intact families. Among the health concerns that should be addressed are asthma management, based on the OIG asthma report submitted to the Director on June 25, 1999, and immunizations. The Commissioner of the Chicago Department of Public Health and a registered nurse who serves as a consultant to the OIG should be included in this meeting. The OIG recommends that this meeting be hosted by the private agency involved in this case in which immunizations were an issue.

The Department agreed. The Department's Division of Health Policy has hired a new Chief Nurse and will work with the Divisions of Operations and Child Protection to train supervisors on health and compliance issues among intact families.

4. The OIG will meet with the private agency to discuss the findings and recommendations contained in this report.

The Department agreed.

The Inspector General met with the Executive Director of the agency and members of the Board of Directors in March, 2000.

Death Investigation 5

ALLEGATION

A three year-old boy was beaten to death by his mother's paramour. His mother had an open family case with a private agency until four months prior to his death.

INVESTIGATION

The mother, who had six children, gave birth to her first child when she was 14 years old. She first became involved with the Department in 1992 following three hotline calls regarding the care of her first two children. The reports were indicated for abuse, failure to thrive, medical neglect and inadequate supervision and the two children were taken into custody by the Department. The private agency that received the case placed the older child in a relative foster home with a goal of adoption while the other child eventually went to live with his father. The mother did not participate in services and had no contact with the agency.

The child who was the subject of this investigation was born in 1995. At the time of his birth he tested positive for PCP and his mother admitted smoking PCP-laced cigarettes several times per week up until the time she delivered her child. The Division of Child Protection (DCP) investigator assigned to the case believed the mother was remorseful about her drug use and was sincere in her desire to stop. Although the investigator was aware two of the mother's children had been removed from her custody, she did not review the files from those previous investigations. The investigator told the OIG that this was the first case she had handled involving PCP and that it was policy for drug cases to be referred to a drug treatment agency.

After mother and child were released from the hospital, the investigator visited them at home where the mother also was caring for her two year-old daughter. The investigator determined the housing situation to be adequate and noted family members were available to assist the mother. The investigator made one more surprise visit to the home prior to closing the investigation. The same day the DCP investigator made the surprise visit, the private agency worker assigned to the case wrote in her notes that she had unsuccessfully attempted to locate the mother at her last known address and listed her whereabouts as unknown. The mother's address had not changed since the agency first received the case. The caseworker continued to work towards the adoption of the oldest child by his relative but failed to make any attempt to provide services to the mother and was unaware of the mother's two year-old daughter.

For three years the family had an open case with the private agency during which time four hotline reports were made against the mother, though all were unfounded. In March and April of 1998 the boy, who was three years-old by that time, was taken to a hospital emergency room twice with acute abdominal pains accompanied by bruises on his back and stomach. Hospital staff believed the injuries were the result of abuse and contacted both the hotline and the private agency. The caseworker told hospital staff the mother had been compliant with medical follow-up for her children. The hospital also noted the presence of the mother's paramour at the hospital. No criminal background check was done on the paramour at the time and the child was eventually released to his mother's custody. Subsequently, while the mother spent four days away from home using heroin, the paramour beat the child to death. A criminal background check of the paramour conducted during the OIG investigation showed he had a history of arrests and prison time for drug-related charges including a conviction for a PCP offense.

The worker's supervisor from the private agency told the DCP investigator who was assigned to the fourth report that led to an indicated finding against the mother that the caseworker was "her worst" at the time. After the agency was notified of the PCP positive birth, they allowed the same worker, in whom they apparently had little confidence, to continue with the case. The worker assigned to the case had since left for a job at another agency and was eventually discharged from that position.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1.The article "PCP Pharmacology: An Overview" 1998, should be distributed to all DCP investigators and incorporated into the curriculum for training of DCP investigators. An understanding by investigators of the dangers of PCP is critical to the assessment of safety and risk of children.

The Department agreed. A copy of the article has been forwarded to the Division of Training for inclusion into the training curriculum for child protection investigators. The article will also be reviewed with each child protection team by the supervisor at team meetings.

2. Because of the supervisory deficiencies noted in the private agency records of this case, this report should be shared with the private agency. The OIG is willing to meet with the private agency Director and others of her staff and the Board of Directors.

The Department agreed.

The Inspector General met with the agency's Executive Director and members of the Board of Directors in September, 2000.

Death Investigation 6

ALLEGATION

An 11 year-old boy was shot and killed 10 days after running away from a foster home. The boy had been involved with the Department for one month prior to his death.

INVESTIGATION

The boy's family became involved with the Department when hospital staff called the hotline to report inadequate supervision after the boy's mother was admitted to the hospital for a drug-induced asthma attack. The child was placed with a relative and, following the mother's non-compliance with services, a temporary custody hearing was scheduled. The boy ran away from his foster home prior to the court date and a juvenile arrest warrant was issued. After he was located, the boy was placed in another foster home but stayed there for only three days before running away again. Although the boy ran away on a Sunday, his foster mother did not report it until Monday because her licensing agency was closed and she did not have pertinent information such as the boy's last name or his social security number. Ten days later the boy was accidentally shot by a 16 year-old. He died the next day.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **In January, 2000, in response to prior OIG recommendations, the Department implemented new procedures to improve the way the Department reports and attempts to locate missing, runaway and abducted children. The death of this child in December 1999 underscores the importance of such procedures. Additionally, with use of the new Child Identification Form, foster parents will know the last name of the child placed with them.**

This report has been shared with the appropriate Regional Administrator and the Department's Runaway Coordinator.

GENERAL INVESTIGATIONS

General Investigation 1

ALLEGATION

A foster mother was indicated for fractures on a three month-old infant placed in her home. The foster mother appealed and the Department reversed the indicated finding. Subsequent to the reversal, the Department placed a pair of sibling toddlers in the home. One month after the children were placed, the foster mother took one of them to the hospital where doctors diagnosed the child as a victim of shaken baby syndrome.

INVESTIGATION

The three month-old was the first child placed in the newly licensed foster mother's home. Doctor's notes from an examination conducted soon after the placement stated the infant, who had been born drug-exposed, exhibited stiffness in his legs and random jerking movements in all extremities. Attending physicians could not determine the cause of these behaviors. The foster mother mentioned to a social worker that the boy's right leg seemed weak and he kept it curled against his body. One month after the boy's placement, the Department placed a one month-old girl in the home. One month following that placement, the foster mother took the three month-old to the emergency room stating the infant cried any time his right leg was touched or moved. Doctors found the infant had a fractured tibia and a possible healing fracture of the femur. A hotline call was made and both children were removed from the home. Following a DCP investigation, the foster mother was indicated for bone fractures and significant risk of physical injury.

The foster mother requested an Administrative Appeal Hearing. The infant had only been in her home for two months when the fracture was discovered, and medical experts could not determine that the fracture occurred during that time. Prior to the hearing, the Department referred the matter to its regional counsel who determined that since the age of the injury could not be established and medical attention was sought, there was insufficient evidence to conclude that the foster mother had abused the child. The Department unfounded the report and immediately expunged the mother's record of any reference to the allegation. In cases where allegations of serious injury are unfounded, Department policy requires SCR to maintain a record of the report for three years. The Department's Licensing division is required to investigate all allegations against foster homes regardless of the final determination. The Licensing investigator assigned to this case told the OIG she did not follow through on her first attempt to visit the home because the foster mother, acting on her attorney's advise not to discuss the case with anyone, refused to cooperate. After the children were removed from the home, the Licensing investigator did not attempt another visit.

After the indicated report was expunged and the home was taken off of "hold" status, the Department placed a three year-old girl and her two year-old brother with the foster mother. The children's caseworker told the OIG she had no knowledge of the foster mother's previous indicated report or its reversal by the Department. Six weeks after the children were placed in the home, the foster mother took the three year-old girl to a hospital emergency room where doctors diagnosed the child as suffering from shaken baby syndrome. The Department subsequently indicated the foster mother for abuse.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **Licensing Procedures should be amended to clarify that after an unfounded or indicated finding that does not serve as a bar to licensure, licensing must complete its investigation. The investigation should determine whether: 1) the facts support a licensing violation, or 2) there remains a reasonable possibility of abuse or neglect suggesting the need for additional safety measures.**

The Department agreed. New procedures are currently being developed between DCFS Licensing and Child

Protection to assure the most concurrent comprehensive investigation and licensing review. This arrangement is currently in operation on an informal basis pending the issuance of an official policy transmittal.

2. The Appeals Unit must refer any expunged investigation of abuse or neglect in a foster or daycare home back to the Licensing Division for a licensing investigation. This investigation may need to be limited to a determination of the need for additional safety measures where there remains a reasonable possibility of abuse or neglect. A copy of the unfounded DCP investigation or the indicated report that has been reversed must be forwarded to the licensing representative. The licensing representative may want to consult with the Guardian ad Litem and, in appropriate cases, with the Medical Director of the Department. If necessary, the licensing representative shall put in place reasonable protective measures and/or restrictions for the home. These could include placing a homemaker in the home, extra monitoring, and restricting the number and the ages of the children in the home. These restrictions must be noted in the licensing file and given to the Placement Clearance Desk. Placement Clearance Desk staff shall place this information in the data system and provide such information to the workers when they call to obtain clearance for their placement.

The Department agreed but, under the agreement stated in the response to the previous recommendation, licensing will have already completed a licensing review by the time a finding is expunged.

3. Presently, DCFS Rule 383.7 provides that a licensing investigation shall not be conducted when the "alleged violation occurred more than 60 days before receipt of the complaint..." The Department must amend this rule so that a licensing investigation can be conducted upon the completion of an unfounded report of abuse or neglect or the reversal of an indicated report of abuse or neglect. The licensing investigation may need to be limited to the issue of additional safety measures in the foster home or daycare facility.

The Department agreed. Rule 383 is currently being revised. As part of the revisions, Section 383.7 is being changed to remove the directive not to conduct a licensing complaint investigation when the "alleged" violation occurred more than 60 days before the receipt of the complaint.

4. In investigations in which there is credible evidence of abuse or neglect, but the perpetrator cannot be identified, the investigation must be indicated for abuse or neglect by an unknown perpetrator. The Department needs to communicate to the Hearings Unit and legal staff that when the perpetrator cannot be identified, the report should not be expunged but indicated to an unknown perpetrator.

The Department agreed. A copy of this report has been shared with the Administrative Hearings Unit and the Office of Legal Services.

5. The Department must amend its Rules and Procedures that conflict with the statutory requirement to retain certain unfounded allegations for three years.

The Department agreed. The Department has ensured that investigations that are overturned during expungement proceedings will also be retained for three years.

General Investigation 2

ALLEGATION

A couple severely beat their 11 year-old adopted daughter and kept her locked in their basement over the course of a five day alcoholic binge. The foster mother was a contractual employee of the Department as a Master Adoptive Parent.

INVESTIGATION

The mother, who had adopted three former foster children and had two additional foster children in her home, had recently married. The adoptive parents told police they became enraged when they caught the girl sexually acting out with a foster child in their home. The mother hit the girl repeatedly in the face, then locked her in the basement and kept her from going to school for several days out of fear the beating would be detected by school officials. Over the ensuing five day span, the couple took turns drinking alcohol and beating the child with their fists and the husband also hit her with a wooden object. At one point, the mother threatened to kill the girl and hit her over the head with a handgun. The child was not allowed to use the bathroom and received only one meal a day. Eventually, when the husband left to take another child to school and the mother fell asleep, she escaped, traveling to her school where administrators alerted authorities. The parents were convicted of Aggravated Battery on a Child and Unlawful Restraint and each was sentenced to five years in prison.

Before the Department awarded her a contract as a Master Adoptive Parent, a background check revealed she had been convicted of Driving Under the Influence. The Contract Administrator approved the hiring after reviewing the mother's history as a foster parent and receiving a letter from her explaining the arrest as an isolated incident. A condition of her contract was that she could not transport children in her car. After joining the Department, the mother had her foster parent license transferred to a private agency to avoid any apparent conflict of interest. The Department never informed the private agency that monitored her foster care that she had a DUI conviction, nor was it told the Department had deemed her unsafe for driving children. Two years later, the Department's Bureau of Licensure and Certification informed the private agency that the mother had a criminal history but did not provide specifics. A background check conducted by the Illinois State Police for the private agency showed only an almost 20 year-old conviction for leaving the scene of an accident and vehicle damage. In light of her service since then, the private agency requested and received a licensing waiver from the Department. Her husband cleared a background check soon after they were married.

Several of the mother's co-worker's in the Department believed she had a drinking problem. Her supervisor asked his superiors, including one who was aware of her past DUI conviction, how to address the situation but was given limited guidance. When the supervisor confronted her directly she reacted defiantly and began staying away from the office. Due to confidentiality concerns, the prohibition of driving children was explained as a job description adjustment, even to her supervisor who remained uninformed of the DUI conviction. The mother's co-workers stated that they never observed her actually drinking on the job and since the Department had licensed her as a foster parent, it was none of their business.

The private agency caseworker assigned to the adoptive mother's foster children had received allegations of corporal punishment of children in the home and other concerns, but failed to meaningfully investigate the charges. His notes detailed an instance when the 11 year-old attempted to wake the mother but was unable to do so. On multiple occasions, the caseworker relied on the mother's unverified explanations combined with her reputation and standing to discount potential risks to children in the home.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **Implement policy and train administrators on how to respond to *suspected* contractual and employee drug and alcohol abuse. The policy should address confidentiality, and appropriate supervisory procedure, response and documentation. The procedures should also**

address what signs to look for regarding drug and alcohol abuse.

The Department agreed. The DCFS Office of Health Policy and Office of Employee Services are coordinating this effort.

2. Discipline the supervisor's superior for (1) his failure to appropriately notify the adoptive mother's supervisor and the private agency of the mother's DUI, driving restriction, and apparent drinking problem, and (2) his failure to provide guidance or otherwise address suspicions of alcohol abuse. As he was the only one aware of both the ongoing alcohol abuse and the DUI, as well as the mother's status as a foster parent, he is most culpable.

This worker left the Department in December 1999.

3. Distribute policy and develop training for private agencies and Central Licensing reiterating the need for thorough factual investigations, whenever possible, and the need for corrective action plans that are capable of being monitored. Licensing workers must be required to share information with caseworkers that may be relevant. Specific guidelines defining relevancy should be included.

The Department agreed. The DCFS Division of Operations and Purchase of Services are coordinating to develop training on this issue.

4. The private agency should counsel the caseworker for failing to adequately assess and investigate the allegations of corporal punishment against the 11 year-old and the other children in the home.

The Department agreed. The caseworker is employed by a private agency. The Department has no authority to administer counseling. It is the Department's understanding that the OIG has raised the issue with the private agency.

The Inspector General met with the agency's Executive Director to discuss the report, including the recommendation for counseling, in May, 2000.

5. During this investigation, it became apparent that the adoptive mother's field office was severely affected by the news of the girl's beating. Many of the staff admitted to serious soul-searching and replaying past events to determine whether any actions they could have taken may have changed the course of events. The OIG recommends that the staff meet with the Ethics Board to discuss ethical concerns raised in responding to substance abuse and in addressing the mother's dual status as a co-worker and a foster parent.

The Department agreed.

The OIG's Ethics Board will meet with the field office's staff.

6. Portions of this report should be distributed to private agencies as a teaching tool on the dangers inherent in failing to adequately assess and investigate licensing complaints.

The Department agreed.

General Investigation 3

ALLEGATION

During the course of an OIG investigation it was learned that a foster home the OIG had previously recommended be put on hold status was still accepting wards for placement.

INVESTIGATION

A 1996 court order had prohibited any children from being placed in the foster home following a pediatrician's examination of a child in the foster mother's care. At the time, the doctor found that the two and a half year-old girl suffered from medical and hygienic neglect and the child's motor skills had failed to develop properly. Despite the court order, the woman's foster home license was renewed five months later. In October of 1999, three children were placed in the foster home.

In January 1998, the OIG had sent a memo to several Department administrators reminding them that no children were to be placed in the home. In July of 1998, a counselor called the hotline to report that her client, a former Department ward, had been sexually molested while living in the home in 1996. The former ward was also concerned that the behavior exhibited by her children, who had lived with her in the house, suggested they also might have been victims of abuse while in the home. Although the foster mother's adult children had lived with her in the home, criminal background checks were never conducted for them.

In January 2000, the Department administrator responsible for overseeing restrictions on foster homes, who had received the OIG's 1998 memo, faxed a memo to the Placement Clearance Desk (PCD) requesting that the home be placed on "hold" status as of January 1996. The PCD replied that it could not issue a four-year retroactive hold on a foster home. Two months later, the administrator faxed a revised request and the home was placed on hold status.

In March 2000 when the OIG learned that the woman's foster care license was still active and there were children placed in the home, a criminal background check was conducted on the woman's adult children. The check found that her 38 year-old son had a 20 year criminal history including convictions for rape, aggravated kidnapping, deviant sexual assault and indecent liberties with a child. He was not registered with the state as a criminal sex offender. The son had been arrested three times for domestic battery in the previous three years and had given his mother's house as his home address on each occasion.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

Given the serious concerns regarding the safety of children placed in the home, the OIG recommends that the Department should act to revoke the foster home's license.

The children have been removed from the home. The foster home has been placed on "hold" status to prevent the further placement of children.

General Investigation 4

ALLEGATION	The OIG received a complaint from a teacher that a DCP investigator had been unprofessional and verbally abusive in his dealings with the school and a teen mother/student.

INVESTIGATION

The investigator had been convicted of Aggravated Assault in 1992 while he was employed as a probation officer. The investigator had gone into the field with an intern and at some point held a loaded gun to the intern's head and threatened him. The investigator was suspended pending disciplinary action but resigned before the matter was resolved. The Aggravated Assault conviction was later expunged from his record. When the investigator applied for the position with DCP, he answered "no" to the question regarding whether he had ever been convicted of a felony.

The Department had failed to discharge the investigator after learning of the conviction because it received outside legal advice that the Civil Rights Act barred firing an individual under those circumstances. While at his current job, he had allegedly threatened to kill his supervisor and feed her to alligators. Although the supervisor stated that she thought he was dangerous, the co-worker who overheard the statement stated that he believed the alleged threat had been made in jest. The department believed it could not go forward with discipline.

INVESTIGATIVE REFERRAL	**The OIG contacted the Department's Labor Relations office and provided them with all the information and documents that had been obtained. The Department attempted to discharge the worker, but an arbitrator reinstated.**

General Investigation 5

ALLEGATION The OIG received a complaint that a 72 year-old woman, suffering from dementia, was wandering the neighborhood streets at night with her six-year-old adopted son. The complaint also alleged that the Department had failed to take measures to protect the boy from potential danger resulting from the mother's condition despite calls to the hotline.

INVESTIGATION The boy lived in the relative foster home of his great, grand maternal aunt for five years before she adopted him. A review of the caseworker's notes from the months prior to the adoption showed the mother demonstrated a pattern of confused behavior. She forgot appointments that had been scheduled just a few days before and repeatedly claimed she lost or did not receive her monthly foster care checks from the Department, though it was later shown that all had been deposited and had cleared. The woman's daughter, who was the foster parent for one of the boy's older siblings and was involved with the same caseworker as her mother, told the OIG that she learned of the impending adoption only one month before it was completed. She was concerned at the time that her mother seemed forgetful and had not been paying her bills but did not express these concerns to the caseworker. The woman's other daughter told the OIG that she learned about the adoption after it was finalized.

After an elder abuse investigator called the hotline to report the mother and child were roaming the neighborhood, the case was assigned to a DCP investigator. The DCP investigator interviewed the mother, who told him she had a mild case of Alzheimer's but that her daughter came by daily to help out. At the time of the interview, the DCP investigator determined that the mother was lucid and the child was at no risk of harm. The DCP investigator neglected to interview the reporter of the hotline call as required by investigative procedure. Although the DCP investigator recorded an interview of the woman's daughter, she did not attempt to corroborate the information obtained. The DCP investigator also failed to contact a Department dependency specialist even though his supervisor instructed him to do so. The DCP investigator also did not attempt to obtain access to the mother's health records. A medical report completed by a neurologist contained in the mother's health records noted that she had previously suffered a stroke and had been experiencing progressive memory loss for the past year and a half. The report also reflected concern about the mother living alone without constant supervision. The investigator unfounded the case and his supervisor signed off on the report.

Six months after the first DCP report was unfounded, hospital staff called the hotline to report that the mother's disease had progressed to the point where she was unable to continue caring for her son. A second DCP investigator was assigned to the case by the same supervisor. The investigator interviewed the mother who told her she was able to care for her son with the help of her two daughters. During the interview, the mother stated her age as 62, 10 years less than her actual age, and said the adoption had been completed three years earlier when it had actually occurred less than a year before. The investigator told the OIG that she was aware at the time of the interview that the information was incorrect. One of the woman's daughters told the investigator that she and her husband were moving into a new home, at which time her mother and her adopted son would move in with them. The DCP investigator developed a care plan and indicated the mother for lack of supervision and risk of harm. Based on the assertion that the daughter was going to move into her mother's home to provide assistance until the new home was ready, the DCP investigator closed the investigation. However, neither of the daughters moved in with their mother and she was unwilling to move in with either of them, leaving the situation unchanged.

Three weeks after the second DCP investigation was concluded, staff at an Alzheimer's clinic called the hotline to report that the woman's disease had advanced past the point where she could be expected to provide adequate care to her son. The DCP investigator who handled the first report was assigned to the case. The investigator interviewed the mother, her son and school personnel. All stated that the mother was an adequate

caretaker. The investigator did not contact the source of the hotline report, a doctor at the Alzheimer's clinic. The investigator had gotten the mother to sign a consent to release her medical records but he never obtained a copy of her medical history. The doctor's notes in the medical records reflect that the mother's condition had worsened. She was incapable of managing her medication and her forgetfulness had become more dangerous as she was leaving burners lit on her stove. One of her daughters told the doctor that her mother became extremely agitated when she was away from her own house and refused to stay in either of her daughters' homes. The daughter also confided to the doctor that she believed the boy was a stabilizing factor in her mother's life and was fearful of what would happen if he was removed from her care. Unaware of this information, the DCP investigator completed a safety assessment plan concluding that the child was at no risk and unfounded the case. Four days later, a fire damaged the mother's home, forcing she and her son to move in with one of her daughters.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. This report should be reviewed with the first DCP investigator. He should be counseled on his failure to conduct basic investigative procedures and follow supervisory direction from both his supervisor and the clinical consultant/field teacher.

The Department agreed. Appropriate disciplinary action is being pursued.

2. This report should be reviewed with the DCP supervisor. She should be disciplined for lack of adequate supervision on the investigations of the family and for her failure to ensure that investigators under her supervision understand and carry out instructions.

The Department agreed. Appropriate disciplinary action is being pursued.

3. This report should be reviewed and discussed with the second DCP investigator. Investigation issues should be reviewed for learning purposes with the Department trainee who accompanied the investigator.

The Department agreed. The report was shared with the investigator.

4. The OIG will share this report with the private agency that completed the adoption. Because this is one of two cases the agency is handling involving older caregivers and dependency matters, the agency should establish an independent team to review their foster care and home of relative cases involving older caregivers who are being prepared for adoption and subsidized guardianship. The OIG will provide the agency with the report on the Older Caregiver service model.

The Department agreed.

The Inspector General met with the agency's Executive Director and members of the Board of Directors in December, 2000 to discuss the report.

5. The Department should reconsider prior OIG recommendations pertaining to the development of a dependency allegation category and handling of dependency reports by SCR and child protection investigators. The Department must ensure that SCR staff is properly trained to appropriately handle dependency related allegations. The Department's established procedures for referring dependency cases to its Child Welfare Services unit, needs to be implemented.

The Department agreed that SCR should route dependency reports to the child welfare intake unit that do not suggest an imminent risk of harm. However, in urgent situations where there is imminent risk of harm, those

reports should go to the child protection units. The Department also agreed that DCP workers should be trained to respond more effectively to urgent dependency situations than to reroute them to the child welfare unit.

6. This case represents some of the most difficult issues facing workers. The possibility of removing children from 'grandparents' with whom they are closely bonded calls for special supervisory advice for the workers. The Department should develop an independent relationship with a gerontologist to be available to workers. Workers and their supervisors must pay attention to these cases involving older caregivers in order to arrange for consults.

The Department has entered into a contract with a private agency to provide services to families with older caregivers. An information transmittal will be sent out explaining the availability of the agency's services.

General Investigation 6

ALLEGATION

The OIG received complaints alleging that in three separate cases a Division of Child Protection investigator failed to properly assess risk factors or actively ensure that children were safe.

INVESTIGATION

The first case involved a two year-old girl who died from severe scalding burns to both legs. The mother surmised the child must have climbed in and out of a bathtub filled with hot water while she and her eight year-old sister were in the bathroom unattended. Medical personnel believed the mother's account was inconsistent with the burn pattern caused by immersion. The investigator did not conduct required or necessary interviews in a timely manner, if at all, and did not investigate the scene of the incident as directed by his supervisor. He also failed to determine if the eight year-old sibling was at risk. The investigator did not take protective custody of the eight year-old. The Medical Examiner ultimately ruled the child's death a homicide, at which time the mother was arrested and the eight year-old was removed and placed with her father.

The second case involved a mother and newborn baby who both tested positive for opiates and cocaine. The investigator interviewed the baby's parents after the mother and the child were released from the hospital. The mother told the investigator she smoked crack cocaine on a weekly basis but had cut down prior to the birth and was seeking treatment. The investigator completed an Adult Substance Abuse Screen, answering "no" to all questions despite the presence of obvious drug issues. The investigator did not request criminal history checks of the parents because he believed they were only done for placement purposes. The infant's father had an extensive criminal history including convictions for aggravated battery and delivery of a controlled substance. The investigator indicated the mother for the baby's drug exposed birth and was supposed to assume the responsibilities of an intact family worker per his job description. Two months later the mother abandoned the child at her maternal grandmother's house. There was no evidence the investigator provided any services to the mother during the time between the two hotline reports.

The investigator placed the infant with her father but did not interview or check the background of his niece whom the father said would serve as a primary caregiver. After an incident in which the mother returned to the father's apartment and barricaded herself and the child inside until the police intervened, the infant was taken to the Emergency Resource Center. The father told the investigator he could not care for his daughter and requested the Department take custody. When the investigator attempted to screen the case with the State's Attorney's office, he did not report the father's criminal history or his request for the Department to take custody. The State's Attorney recommended keeping the case open in order to provide intact family services and monitor the father and infant. The investigator did not consider relatives as possible caregivers for the infant. The child was later taken into temporary custody by the Department and placed in a foster home.

The third case involved a 17 month-old boy living with his mother who had a long history of drug abuse. Of the ten children the mother had given birth to, four were born substance exposed, one of whom died. The mother's parental rights were terminated on all surviving children except for the 17 month-old. The investigator was assigned to the case in response to a hotline call regarding potential risk to the child in her care. The investigator interviewed the mother who told him she had not used drugs for some time and was planning to participate in drug treatment. The investigator called the drug treatment agency to confirm the mother's appointment and was told they had no record of being contacted by the mother. Over the next two months, the investigator documented four unsuccessful attempts to visit the mother's home. The investigator then attempted to screen the case into court, but the State's Attorney's Office did not feel the investigator presented a strong enough argument to justify pursuing a child protection warrant. The State's Attorney

returned the case to the investigator with instructions to locate the mother and child and determine whether the child was at risk. The investigator located the mother who told him she was in drug treatment at a different agency. That agency informed the investigator the mother had completed an initial assessment and kept one appointment. Soon after, a hotline call reported the mother had two positive drug tests. The investigator was asked but did not attend a case staffing at the treatment facility. He also failed to assess risk of harm to the child and could not locate the child after being ordered by the judge to bring the child to court. The child was found and the Department was granted temporary custody.

While conducting these three investigations, the investigator failed to follow basic investigative procedures or provide follow-up services. His skills and practices are substandard for a worker with his years of experience in the field. He demonstrated poor judgment, a lack of basic knowledge to conduct adequate investigations, poor assessment skills, an inability to exercise critical thinking and an inability or unwillingness to follow supervisory instruction. The investigator ignored information that was critical in completing assessments and making decisions. Consequently, what he did or did not do in these cases endangered the children involved. Because he demonstrated an attitude of indifference towards the job and a lack of motivation to perform up to minimum standards, available training would be insufficient to make him a good investigator or caseworker.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should consider terminating the investigator's employment.

If the investigator is permitted to continue his employment with the Department, he will require a highly experienced and knowledgeable supervisor who will provide very close supervision, detail all instructions with timelines for completion, verify that he has followed instructions, and verify his contacts and the content of his interviews.

The Department agreed. Appropriate discipline, up to and including discharge, is being pursued.

General Investigation 7

ALLEGATION Six siblings, four boys and two girls, and a two year-old foster child were removed from their home after it was alleged that the mother hit one of the two youngest boys, who are twins. The mother was also accused of using excessive discipline against the twins causing mental injury. The foster parents contested the removal of their children and appealed the removal of the foster child. The foster child was placed in the home of a contractual Department employee who worked in the same office as the boy's caseworker. The contractor allegedly reported to the child's daycare that she would be adopting him. The OIG was asked to investigate the handling of the case and possible conflict of interest.

INVESTIGATION The couple had originally been licensed as foster parents in another state. When they moved to Illinois they became licensed through the Department but later transferred their license to a private agency in order to participate in a specialized foster care program. The couple adopted four of their six children, including the twins, through the private agency. Three years later, the private agency informed the couple that they would not place additional foster children in their home. The couple transferred their foster care license back to the Department. Within a week of the transfer, an infant was placed in their home.

From the time the couple was licensed in Illinois, the foster mother was the subject of several unfounded reports to the hotline including allegations of physical abuse of the children and her husband. At one point, the Department removed the foster child from the home following a report of domestic abuse. Although the DCP investigation was unfounded, a licensing investigation ensued. The local licensing investigator substantiated the complaint and the couple was required to attend marriage counseling and keep the Department informed of any significant incidents that might affect the stability of their relationship. The couple fulfilled the requirements and the foster child was returned to their home. In January 1999, the husband moved out of the family home due to ongoing marital difficulties, however the couple did not inform the Department of their separation. In addition, the father testified at the foster child's parental termination hearing that he and his wife intended to adopt the boy. The court decided to terminate the natural father's parental rights. The boy's mother signed a surrender of her parental rights the same day.

After a hotline call was made alleging the foster mother struck her adopted son, all of the children were taken into protective custody and removed from the home. The couple's children were placed with the paternal grandparents while the foster child was placed in a temporary shelter. The foster mother was granted supervised visits with the boy, however Department workers decided to suspend visitation after two sessions. The decision was based in part on the child's behavior following visits and the chronic problems that plagued the couple's relationship. The workers were also aware that the Assistant State's Attorney (ASA) strongly opposed visitation and would fight any future attempt to return the child to the couple's home. The caseworker's supervisor told the OIG that the ASA in that region "always wins," rendering any effort to maintain a relationship between the boy and the foster parents futile. The workers wanted to place the child in a pre-adoptive foster home but were unable to find a suitable placement from their available pool of foster parents. The Department workers then asked the Local Area Network (LAN) resource recruiter if she would take the child. The LAN recruiter said that she was interested in adopting a child and agreed to have the boy placed in her home. The LAN recruiter was licensed as a foster parent through an agency that only dealt with teenagers. In order to have the child placed in her home, she transferred her license to the Department.

When the foster parents learned that the child had been placed in the pre-adoptive home of a contractual Department employee, they complained to the Department's Administrative Hearing Unit that they were being denied an opportunity to have the child returned to them before the matter had reached a final resolution. Following receipt of the complaint, two Department Administrators instructed the caseworker to

arrange a visit between the foster parents and the child. Upon learning of the scheduled visit, the LAN recruiter called the caseworker to voice her opposition to the planned visit. The caseworker and her supervisor then participated in a series of phone calls with several interested parties. One call was from the Assistant States Attorney who strongly disapproved of the decision. Following these phone conversations, the caseworker and her supervisor decided to cancel the visit.

Soon after the boy was placed in the LAN recruiter's home, the child's daycare teacher registered a licensing complaint against her. The teacher alleged that the LAN recruiter had exhibited inappropriate parenting behaviors when dealing with physical altercations between her own children and the foster child. She also stated that the recruiter had freely told her confidential information regarding the child's background, his natural mother and the foster parent's impending divorce. The licensing investigator interviewed the LAN recruiter and her children who denied the allegations that she had not properly addressed physical altercations. The recruiter explained to the investigator that she had shared the information about the foster child with the teacher because she viewed her as a fellow child care professional. The licensing investigator instructed the recruiter to be more cautious with confidential information and unsubstantiated the complaint.

The caseworker, her supervisor, the local foster care support specialist and the LAN recruiter all acknowledged to the OIG that they were familiar with each other as professionals but stated that they were not friends and did not know each other socially. The caseworker and her supervisor stated that they were aware that Department employees could not be licensed for foster care through the Department but believed the LAN recruiter was exempt from this rule because she did not work directly for the Department but was a sub-contracted employee.

There were improbable similarities in the medical histories of the children, who were from four different biological families. Several of the children had been prematurely diagnosed with Attention Deficit Disorder (ADD) and/or Attention Deficit Hyperactivity Disorder (ADHD) and had been prescribed psychotropic drugs for these conditions without adequate substantiation of a problem, monitoring or follow-up care. The medical histories also indicated that although several of the children were diagnosed with asthma, no long-term asthma management plans were implemented to ensure the children's health and safety. Two of the boys had had surgery to enlarge their urethras.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

Conflict of Interest

1. The Department needs to develop alternatives to minimize conflict of interest relationships and biased decision making. The following recommendations are not intended to be exclusive:

- **Rule 437, which addresses Department employee sources of income and conflicts of interest, should be amended to remove the exception allowing DCFS Foster Parent Support Specialists to be licensed for foster care by DCFS. The Rule should not permit any exceptions.**

  The Department is collaborating with the OIG and representative Foster Parent Support Specialists to effect this recommendation. The Department has filed draft Rule 402 with language that prohibits Foster Parent Support Specialists from licensure with the Department if they also contract with DCFS to provide services.

- **DCFS should notify, in writing, all DCFS field offices and private agencies that Department and Agency employees must not be licensed for foster care by their employer or an entity with which they have a working relationship. All employees currently licensed for foster care by their employer**

or an agency with which they have a working relationship must transfer their license immediately. The Department should conduct a random audit to verify implementation of this recommendation.

Department Rules and Procedures currently provides for DCFS employees that are licensed foster parents to be licensed by an agency other than the Department. The Department agrees to explore the feasibility of the OIG's recommendation to mandate private agency employees that are licensed foster parents to be licensed by an agency other than their employer.

- **All private agency and Department employees must be (re-)trained on Rule 437 and conflicts of interest.**

  The Department agrees to work with the OIG to develop alternative training possibilities.

- **All DCFS employees should be encouraged to approach the DCFS Ethics Board when faced with a possible conflict of interest.**

  The Department agrees to work with the OIG to develop alternative training possibilities.

- **All DCFS contracted employees should sign a Conflict of Interest Statement when signing their contracts. A copy of the Statement must be maintained with the contract. All contracted employees should receive a copy of the Code of Ethics for Child Welfare Professionals.**

  DCFS Executive Staff will be provided clear direction that they must have all contractual staff sign a conflict of interest statement and be provided a copy of the Code of Ethics.

<u>Licensing</u>

2. When foster families transfer their licenses, the receiving agency or DCFS must discuss the reason for the transfer request with both the family and the former supervising agency. The discussion should be recorded in the licensing file.

The Department agrees.

3. DCFS should revoke the couple's foster care license.

There is not sufficient compelling evidence to support revocation of the couple's foster care license at this time.

<u>Medical</u>

4. The Department needs to develop guidelines to implement Rule 325 which governs the administration of psychotropic medications to children for whom the Department is legally responsible.

The Department agreed. The Department's Offices of Clinical Services, the Guardian, and Health Policy are collaborating on this effort.

5. The Department should consider amending the Child's Summary in the Client Service Plan to include more detailed health and medication information.

The Department agreed. The OIG's recommendation has been incorporated into Best Practice.

6. The Department should consult with a psychiatrist in developing a protocol regarding the Diagnosis and Treatment of wards with ADHD or ADD to include:

- **Behavioral forms should be completed by schools and foster parents when diagnosing and monitoring ADHD and ADD.**
- **Amended Child's Summary in the Client Service Plan.**

The Department agreed. The Department's Offices of Clinical Services, the Guardian, and Health Policy are collaborating on this effort.

7. Create a database to track all children with serious, long-term, chronic medical conditions and/or children who take psychotropic medication. All children in the database should be assigned to a DCFS nurse who will have responsibility for tracking and follow-up. (see OIG Asthma report)

The Department agreed. The Department's Offices of Clinical Services, the Guardian, and Health Policy are collaborating on this effort.

DCFS Personnel

8. The LAN recruiter should be licensed and supervised by a private agency outside the county she works in for as long as she serves in her position.

The Department agreed.

9. The licensing investigator should be counseled about his lack of critical evaluation of the foster parents and the LAN recruiter during the foster home licensing process, enforcement of corrective action plans, and inadequate licensing complaint investigations. The licensing investigator's performance is critical since he is the only licensing worker serving a three-county area. Re-training is also advised.

The Department agreed. The licensing investigator received counseling on these issues. A corrective action plan will be developed to address the re-training.

10. The Acting Field Office Manager should be counseled on the issues and findings in this report and should not be made permanent Field Office Manager of that field office.

The supervisor was not made the permanent Field Service Manager for that area. The information in this report has been shared with her.

11. A redacted copy of this report should be used as a teaching tool for all staff involved with this case.

The Department agreed.

12. The Department's records show an increase in the number of child abuse and neglect calls from the area served by this field office and its branches. The Department needs to examine the population growth in the area and consider increasing child welfare staff to meet projected need.

The Department agreed.

The Foster Child and the Foster Parents' Children

13. The services for the couple's children and the foster child should be adjusted as follows:

- **The medication and behavioral treatment of the couple's children should be reevaluated by an independent pediatric psychiatrist. The psychiatrist must be provided with the medical and school information contained in this report.**
- **The three youngest children should be assessed for their counseling needs.**
- **The three youngest children should receive tutoring to which they are entitled.**

- **An asthma action plan should be developed for the oldest son, the three youngest children and the foster child.**

The court released legal involvement in this case on August 11, 2000. Prior to that, the OIG's case planning recommendations were incorporated.

General Investigation 8

ALLEGATION

The OIG received a complaint from a Department caseworker who had not received certain accommodations she had requested for various physical and cognitive disabilities.

INVESTIGATION

The caseworker had been disabled in a car accident while on her way to visit a ward 11 years earlier. A variety of physical and cognitive problems resulted, some of which have improved, and others of which have worsened, over time. One of these was hearing loss coupled with auditory processing problems which required her to be in a quiet work space. Finding her ability to handle follow-up work and court appearances impaired, the caseworker changed positions

When the caseworker changed positions, she moved to another Department office in a different building, however the ergonomic work station she had been using did not move with her. Subsequently she was scheduled to be moved again, at which time she requested a quiet work space and special phone.

Outside counsel recommended moving the caseworker away from a planned four-person office and referring the matter to the Department's Reasonable Accommodations committee. However, on the date of the move, no response had yet been made to the accommodation request and it became clear that the Reasonable Accommodation committee had not yet been staffed. Outside counsel then recommended that if quieter space were unavailable the Department could consider other measures, prompting the employee to file a claim with an outside federal agency. The caseworker spent a few days in the four person space before being assigned to a quieter area. Several months later she was moved back to the four-person office because the other space was needed for computer equipment.

Since medical updating had not been required in recent years, the OIG recommended that an audiologist who was experienced in workplace assessment to evaluate the employee. Ten months after the caseworker was placed back in the four-person office, she received a two-appointment evaluation, which advised that she work in an area with lessened reverberation and use one of several devices to filter noise or amplify speaker's voices. Operations staff chose to consult the general counsel who advised to forward the recommendation to outside counsel, who recommended earplugs. The caseworker asked that some of the audiologists other recommendations be implemented. The matter is still pending.

Two months earlier, a co-worker who was also disabled and incurred retaliation for providing information to the OIG, was reassigned to another unit in a different building. Any counseling or cautions received in writing were taken back.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Inspector General recommended alternatives for resolution and accommodation of the employees claims.

The Department agreed.

2. Establish a procedure whereby equipment purchased for employees as accommodations follow those employees when their jobs or work locations change; while employees are obligated to "self-identify" if new work locations present new accommodation issues, items like an ergonomic desk or flashing phone are likely to be reusable by someone who has documented a chronic condition.

The Department agreed.

3. The co-worker should be placed in a workplace configuration which would give her access to a photocopier without a great deal of walking, and access to at least open files without lifting.

The Department agreed. The worker has been moved to another DCFS office.

4. Rescind the memos which prohibit an employee from volunteering information to OIG staff, and threatens discipline for doing so.

The Department agreed. The memos have been rescinded.

5. Revise DCFS policy to prohibit retaliation against employees or others who oppose that which they reasonably and in good faith believe to be either unlawful discrimination, or other conduct which violates laws or DCFS policy; as well as retaliation against employees or others who have made an internal or external complaint, testified, assisted, or participated in an investigation, proceeding, or hearing; and to prohibit willful interference with investigations of such conduct by employees or designees of DCFS.

The Department agreed. An information transmittal was issued June 12, 2000, Cooperation with the Office of the Inspector General. This information transmittal stated that the Department will not tolerate any type of retaliation against an employee as a result of initiating a complaint with or providing information to the OIG.

6. Revise DCFS policy to provide for those benefits of the FMLA which are not offered by either the current Family and Responsibility Leave, or Disability, policies of the agency, with the review and approval of CMS; at a minimum, such revisions would allow intermittent leave on a planned or unanticipated basis for those with chronic conditions who have appropriate advance certification by a physician, for therapy, appointments with a medical provider, or time off due to temporary incapacitation.

The Department agreed. The Department's Office of Legal Services and Labor Relations staff are working cooperatively with the OIG on this issue.

7. Ensure that requests for reasonable accommodation are not assigned to a committee at times when no committee exists.

The Department agreed.

8. Develop policy that would require employees to submit periodic (at least yearly) medical documentation as to whether a condition once characterized as chronic in fact continues to require the same type of accommodation, including, where applicable, intermittent leave.

The Department agreed.

9. Advise the manager that comparable discipline is required for comparable conduct by employees of different races, and that if she observes conduct deserving of discipline on the part of someone whose supervisor is not on the premises, that as a manager it is her duty to report the conduct; but that discipline and memos threatening discipline are not appropriate when information is volunteered to or solicited by OIG staff, including written documents provided to OIG staff; and that either conduct under certain circumstances may subject the agency to a charge or lawsuit.

The Department agreed. The manager was advised of the above recommendation.

General Investigation 9

ALLEGATION A clerical employee claimed she suffered a retaliatory demotion with significant loss of pay. Three years earlier she had complained about sexual harassment because of her supervisor's intimate touching of and by a coworker in the office, and preferential treatment of that coworker as to conditions of employment such as raises and the need to reimburse the state for personal long distance phone calls.

INVESTIGATION Following the investigation of her sexual harassment complaint, the clerical employee's duties and reporting relationships began changing. Her evaluations over the next three years reflected much greater change in objectives than had actually occurred, although never calling for clarification of her job description. Her overall ratings did not change, but the tone of her evaluations was much more negative, and the evaluators usually questioned the quality of her relationship with the supervisor about whom she had complained.

Negative notes were entered into the clerical employee's official personnel file that were not in the form of discipline or an evaluation, which could not be responded to or grieved and did not necessarily go to the employee.

A request to revert from a flextime schedule (15 minutes difference in start and end times) to her normal schedule was denied although more substantial time changes were allowed other employees. She received a one-day suspension for accusing her supervisor of "whitewashing" and "interfering" with the sexual harassment investigation. She had received a five-day suspension for an altercation with the same co-worker who had been linked with her supervisor, while the coworker was allowed to resign with nothing in her record about the incident. The sexual harassment investigation was contemporaneous with the altercation and the clerical employee was, herself, blamed for inappropriate language and horseplay. Some language held against the clerical employee was alleged only by the co-worker with whom she had had the altercation.

The clerical employee filed a Central Management Services appeal.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. This recommendation addressed personnel issues.

2. This recommendation addressed personnel issues.

3. This recommendation addressed personnel issues.

4. Cause an internal audit of personnel and labor relations files, and job descriptions, for compliance with CMS and Personnel rules, and sound human resources practices with particular attention to removing medical documents, mortgagor's requests for information, documents which mention proposed discipline or matters under investigation, supervisor's notes to the file, the IDHR national origin and disability surveys, reference checks and similar pre-employment documents and replacing missing evaluation pages. The above-listed and other confidential material should be kept in a separate confidential file, or supervisory file, as appropriate, and securely maintained.

The Department agreed. An internal audit was initiated.

5. Direct the Affirmative Action Office to seek a sign-off from the general counsel's office of its final reports involving alleged sexual harassment by a manager, for compliance with applicable laws, and accuracy of its fact-finding summaries.

The Department agreed. A memo will be sent to the Affirmative Action Office to implement this recommendation.

6. Direct Affirmative Action Office and management staff involved in investigations to honor confidentiality commitments that internal investigators may use in order to obtain information, until and unless use of such information is necessary to fully interview person(s) accused of wrongdoing, or to impose any discipline.

The Department agreed. A memo will be sent to the appropriate staff to implement this recommendation.

7. This recommendation addressed personnel issues.

8. This recommendation addressed personnel issues.

9. When a unit being investigated by the Affirmative Action Office reports to the same person as the Affirmative Action Office, provide an alternative person to do the investigation to avoid a conflict of interest.

The Department agreed and the Affirmative Action Office was informed.

10. Revise DCFS policy on sexual harassment to reflect an intent to comply with the most strict of the various statutory prohibitions which apply to DCFS, and for accuracy on current federal law.

The Department agreed and is currently reviewing the suggested changes submitted by the Inspector General in the October 17, 2000 memo received by the Department.

11. Revise DCFS policy to prohibit retaliation against employees or others who oppose that which they reasonably and in good faith believe to be either unlawful discrimination, or other conduct which violates laws or DCFS policy; as well as retaliation against employees or others who have made an internal or external complaint, testified, assisted, or participated in an investigation, proceeding, or hearing; and to prohibit willful interference with investigations of such conduct by employees or designees of DCFS.

The Department agreed. An information transmittal was issued June 12, 2000, Cooperation with the Office of the Inspector General. This information transmittal stated that the Department will not tolerate any type of retaliation against an employee as a result of initiating a complaint with or providing information to the OIG.

12. This recommendation addressed personnel issues.

13. This recommendation addressed personnel issues.

14. Maintain OES employee's job descriptions on the same basis as those of other employees, and decide salary adjustments on the same basis as other employees.

The Department agreed and job descriptions are now maintained on the same basis.

15. This recommendation addressed personnel issues.

General Investigation 10

ALLEGATION The Department took guardianship of a severely mentally and physically handicapped seven year-old boy after a series of indicated reports for medical and environmental neglect. Despite the Department's involvement, the parents were allowed to continually refuse services. When the family later decided to move to another town within the state, little was done to facilitate the case transfer, which caused confusion for the new workers.

The OIG was asked to investigate due to concerns regarding the move of such a medically complex child and the possible medical neglect and improper handling of the boy's case by the Department.

INVESTIGATION The family came to the attention of the Department in March 1998 due to an indicated report of environmental neglect after the seven year-old was sent to school with head lice and bleeding sores, and his wheelchair was left in the cold. The boy has cerebral palsy, is severely mentally retarded, suffers from hydrocephalus and is blind and deaf. He also has a G-tube inserted into his stomach for feeding and has asthma. In response to the indicated report, the parents were referred to a family preservation program that provided them with parenting education and financial assistance. In June 1998, the private agency referred the case back to the Department for follow-up care.

When the Department caseworker first met with the family, they refused homemaker services. The caseworker believed the family had the right to decline services because the court was not involved in the case. Two months later, the boy's school called the hotline to report that he had arrived at school dirty, smelling of urine, with head lice and roaches in his wheelchair. After another hotline call was made six months later to report that the parents had failed to follow-through with the boy's physical and occupational therapy, the case was brought to court and the Department was awarded guardianship of the boy and his four siblings. The court decided to leave the children in their parent's custody and ordered the Department to provide intensive services to the family. When the boy returned to school, his teachers reported that he was again dirty and in the same general condition. The caseworker's notes for that time period continually stated that the family's home was satisfactory or met minimum standards.

The OIG determined that the efforts of the caseworker in this case were substandard and did not adequately address the various problems presented by this family. The worker allowed the family to refuse homemaker services even after they were mandated by the court and failed to seek court intervention to ensure compliance. Furthermore, the worker minimized problems in the home, such as the repeated presence of roaches and lice, without taking into account the reduced ability of the boy to cope with such hazards due to his physical and mental limitations. The OIG also found the worker's case notes to be incomplete, omitting several significant developments, both positive and negative, including periods when the boy was excluded from school because of his condition and was therefore unable to receive therapeutic services.

The caseworker had two supervisors during the time he was in charge of this case. Both supervisors neglected to ensure a proper level of compliance with Department standards by the family or the worker in this case. Both the worker and his second supervisor at one point signed a court report that characterized the family as "overwhelmed and in need of assistance." Nonetheless, the supervisor did not require the worker at any time to screen the case into court because the two were concerned that such action may have led to the dissolution of the family. While their interest in keeping the family together is understandable, the worker and his supervisor failed to recognize that the Department's primary responsibility was ensuring the boy's health and safety.

In addition, when the family decided to move, the specialist and his supervisor did not readily provide all pertinent information to the receiving workers and relied on them to acquire school and medical records

instead of assisting in the transfer. This failure, when combined with the poor condition of the existing case notes, led to an even greater disruption in services.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Use this report as a teaching tool for caseworkers handling medically complex cases, and to address the importance of case management.

The Department agreed. The report has been forwarded to the Division of Training for implementation into training. The Division of Health Policy will assist in the preparation of materials to discuss the importance and role of case management when dealing with medically complex cases.

2. Counsel the original supervisor on supervisory skills and the importance of more thorough supervision, follow-up and the necessity of using resources.

The Department agreed. Appropriate disciplinary action is being pursued.

3. Counsel the second supervisor on supervisory skills and the importance of more thorough supervision, follow-up and the necessity of using resources.

The Department agreed. Appropriate disciplinary action is being pursued.

4. Counsel the caseworker on case management skills and the importance of follow-up and the necessity of using resources.

The Department agreed. Appropriate disciplinary action is being pursued.

5. Require the caseworker to be monitored closely for a period of one year by his supervisor, and require him to attend additional training on case management and meet monthly with his supervisor for case management meetings.

The Department agreed. These items will be part of the corrective action plan for the caseworker.

6. Require the caseworker's supervisor to approve all critical decisions for a period of six months. The supervisor must also be required to read, review and sign all of the caseworker's case notes for a period of six months to ensure thorough documentation of case occurrences. In addition, the supervisor must provide to the Division of Personnel two written evaluations during a one-year period of the caseworker's case management (every six months).

The Department agreed. These items will be part of the corrective action plan for the caseworker. Following appropriate disciplinary action, the caseworker will be placed on a quarterly evaluation cycle.

7. The Department should perform a database search to identify all cases in which it has guardianship and the child is maintained at home. Each case should be reviewed to determine whether guardianship should continue and whether the child is safe at home.

The Department agreed.

General Investigation 11

ALLEGATION A private agency caseworker was alleged to be romantically involved with the mother of four children whose family case the worker was servicing. The complaint also alleged that the caseworker had failed to remove the children from an inadequate foster home after testifying in court that he would do so.

INVESTIGATION By the time this complaint was made to the OIG, the caseworker had resigned and taken a similar position with another private agency. OIG interviews with his previous co-workers detailed numerous instances that caused them to question the nature of the former caseworker's relationship with the mother, who is developmentally delayed. His former supervisor stated the woman's sister said the mother had a "crush" on the worker and the supervisor once heard the children refer to him as "daddy". The supervisor told the OIG that on more than one occasion the worker denied any personal relationship between the two. Following the receipt of this complaint, OIG staff visited the mother in her home. After initially denying any romantic involvement, she later admitted there had been a relationship but claimed she had ended it. As they were leaving the mother's home, OIG staff encountered the former caseworker entering the home. In his interview with the OIG, the former caseworker acknowledged he had a sexual relationship with the mother which began while he was handling her case. He also confirmed that he had been attending relative visits between the mother and her children although he was no longer their caseworker. He stated he did not believe his involvement with the mother or her children was inappropriate. The worker's previous supervisor had repeatedly informed the worker that such a relationship would be unprofessional, a contention the worker refuted in his interview with the OIG.

While he was still handling the family's case, the worker testified in court that the children's foster home placement at the time was unsuitable because of various environmental hazards. The judge admonished the worker to remove the children as soon as possible. Ten weeks later the worker returned and told the court the children had not been moved, blaming the delay on the licensing department's inaction. The court found the worker had made "no reasonable efforts" to remove the children and filed an emergency motion. The motion was withdrawn after the worker's supervisor removed the children. The supervisor told the OIG the agency then initiated termination of employment proceedings against the worker.

The worker's former supervisor told the OIG that after the worker left the agency, she took over the family's case. She said that, after leaving the agency, the worker made statements to the family that damaged the relationship between the mother and the supervisor to the point that the court ordered the case be returned to the Department for servicing. The agency was later closed due to administrative problems. The OIG could not locate any records from this agency, including personnel files.

The worker's supervisor at his new agency was unaware of the worker's relationship with a previous client. In his application for employment the worker noted a lengthy work history but did not include any previous professional references, providing the agency with personal references instead. He had already missed five court dates in his new position and had been put on a 30-day corrective action plan to improve his work habits. Sign-in sheets at the parent-child visitation center showed the worker had attended sessions between his previous client and her children during work hours.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The worker's new agency should terminate his employment for a number of reasons including:

- **engaging in a sexual relationship with a past client;**
- **engaging in a sexual relationship with the mother when she was a current client;**
- **interfering with the mother's visits with her children;**
- **failing to recognize boundaries;**

- **failing to accurately note his whereabouts and visiting his paramour at her home during work hours without notifying his supervisor;**
- **having a history of court no-shows;**
- **having the court make a finding that he made no reasonable efforts in the mother's case;**
- **making misrepresentations in court.**

The Department agreed. The recommendation has been forwarded to the caseworker's new agency.

2. This report should be shared with the worker's new agency.

The Department agreed. The OIG has agreed to share the report with the agency.

The Inspector General discussed the report with the agency's Executive Director and members of the Board of Directors in November, 2000.

3. The OIG should meet with the worker's new agency's Human Resources staff to discuss their hiring practices and policies. The agency must check references and employment history more vigorously in order to ensure that applicants that are not qualified are not hired to provide child welfare services.

The Department agreed. The OIG has agreed to take the lead on this recommendation.

The Inspector General discussed the report with the agency's Executive Director and members of the Board of Directors in November, 2000.

4. Along with the ethics team from the OIG, the agency should write a new Code of Ethics for its employees. Alternatively, the agency should adopt the Code of Ethics for Child Welfare Professionals in its entirety and make that clear to its employees in the employee handbook that it is currently revising. Its current Code of Ethics is not as strict as the DCFS Code of Ethics, and does not include a definition of conflicts of interest, a discussion of boundaries issues, or a discussion of sexual relationships with clients.

The Department agreed. The OIG has agreed to take the lead on this recommendation.

The OIG met with members of the agency's Board of Directors. The Board agreed to adopt the Department's Code of Ethics and elected to use the OIG's training manual.

5. Agency Performance Teams (APT) should keep all agency records, including personnel records, after an agency closes.

The Department agreed.

6. The Department should initiate a procedure such that employees with poor work performance records are tracked when they leave an agency. If a worker leaves an agency because termination of employment proceedings have been initiated, that information should be shared with APT.

Although the Department agrees with the intent of the OIG's recommendation, the Department has no jurisdiction over private agency hiring and firing of personnel. The Department may only respond to questions from employers regarding past employment records of DCFS staff. Under the new employee licensure rule, the Department will have a repository of all licensed child welfare workers and the status of

each license. Employers may contact the Department to determine if an individual's license is in good standing.

7. Supervisors should be instructed that when they see blatant violations of professional boundaries, they should remove workers from a particular case immediately. Instruction and admonishment is not enough to protect the families that come into the child welfare system.

The Department agreed and will incorporate this recommendation into the Department's training curriculum.

General Investigation 12

ALLEGATION

A 12 year-old boy with an extensive history of asthma-related illness suffered an asthma attack in his foster home. His maternal aunt, the foster parent, refused to call an ambulance or seek medical attention. The boy's teenage cousin called for an ambulance and the child was rushed to the hospital where he was effectively treated. The foster mother was later indicated for medical neglect.

INVESTIGATION

An OIG review of the boy's medical records showed a lengthy history of severe asthma resulting in several hospitalizations including an emergency room visit the night his family moved to Illinois. At that time, the boy was treated and discharged with instructions to return if he experienced further problems. Two months later the child had an attack at school and returned to the hospital where he was again treated and released. He was given a prescription for a steroid inhaler and arranged an appointment to see a doctor. The doctor saw the boy periodically over the next six months, during which time he was brought to the emergency room on two more occasions, the second being the incident that led to the indicated report. The boy's aunt was confused and angry regarding the indicated report and requested a change of primary physicians. The boy's new doctor adjusted his medication to include high-dose oral steroids and created a comprehensive "asthma action plan" for the family. Since that time the boy has not had any further hospitalizations or emergency room visits.

The medical community repeatedly missed opportunities to complete a comprehensive review of the boy's asthma history and therefore prevented him from receiving the necessary treatment to provide relief and control of his asthma. This is particularly disturbing considering the boy was treated by several physicians at the same hospital over a six month period.

The boy's aunt had a poor understanding of his asthma. This was not surprising, considering formal asthma education was never provided to her or the child. Case notes also revealed that the aunt was preoccupied with the knowledge that the boy's parents were both drug abusers and she misunderstood his frequent use of inhalers as a possible sign that he was also showing addictive behavior. This misunderstanding could have been discovered and corrected with basic asthma education. The aunt had no knowledge that the boy's relief inhaler was not adequate for providing long-term control of his asthma. The aunt's refusal to provide help for her nephew's severe breathing problems showed reckless disregard for his well being. Ambulance records documented the extreme seriousness of his respiratory distress when they reached the home. The indicated finding of medical neglect against the aunt was substantiated.

A previous OIG investigation found a marked increase in the annual number of asthma deaths in Chicago between 1979 - 1996, especially during the 1990's. Inner city children with asthma, especially African Americans and Hispanics, may have a three to five times greater asthma mortality rate. This is a particularly disturbing trend given that asthma is a highly treatable condition. As the Department develops and implements its own asthma protocol, it should consider the critical importance of ensuring adequate asthma education for its wards and their caregivers. The Department should fully expect at least 15 to 20 percent of its wards to be asthmatic. The Department needs to provide adequate education through persons qualified to understand and teach the medical implications of its diagnosis. DCP investigators must be aware of the need for asthma care plans and asthma education when investigating complaints of medical neglect involving a child suffering from asthma.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. All Healthworks physicians should receive a pocket copy of the National Heart Lung and Blood Institute (NHLBI) guidelines and a Chicago Asthma Consortium Resource Directory.

The Department agreed. The NHLBI guidelines and Chicago Asthma Consortium Resource Directory went out to all Healthworks physicians on August 30, 2000.

2. Asthma educated caseworkers, foster parents and DCFS nurses are better equipped to identify primary care physicians of our wards who are not following NHLBI guidelines. Education affords the opportunity to effectively discuss and negotiate with the physicians the importance of adherence to the guidelines. Change in physicians is always an option. (See OIG recommendation on asthma protocol in the June 1999 Asthma Report.)

The Department agreed. The asthma protocol, currently in draft form, is intended to give investigators, caseworkers, supervisors and regional nurses the information and guidance they need to ensure the proper treatment of DCFS wards with asthma.

3. DCP investigators should be included in asthma management training. DCP investigators must be made aware of the necessity of asthma action plans and asthma education in medical neglect charges involving children who have asthma.

The Department agreed. DCP investigators will be included in asthma management training.

4. The Department should commend the new doctor who assumed responsibility for the boy's care. His medical interventions transformed a fatality prone asthmatic child, dependent on emergency services, to a normally functioning teenage boy who has not required emergency medical treatment in the last ten months.

The Department agreed and has referred this recommendation to the Department's Medical Director for appropriate action.

5.The Department should share this report with the Chief of Pediatrics at the doctor's hospital and arrange for all our asthmatic wards who are served by the hospital to be treated by this doctor.

The Department agreed and has referred this recommendation to the Department's Medical Director for appropriate action.

General Investigation 13

ALLEGATION As part of an ongoing initiative examining issues specific to pregnant and parenting teenage wards of the Department, the OIG began a cooperative project with a private agency that administers a special program specifically for this population. At a project meeting, staff from the private agency's program presented the case of an 18 year-old ward with a 3 year-old daughter. The mother, her daughter and the mother's 10 year-old brother lived with their 84 year-old grandaunt. The mother had a history of mental illness, drug use, violent outbursts and criminal behavior. There was significant concern as to the grandaunt's ability to protect herself and the young children from the teen mother's explosive behavior.

INVESTIGATION The mother had not attended school or participated in vocational planning since her daughter's birth three years ago. A psychological evaluation indicated the mother had limited intellectual functioning and learning disabilities. She also had a history of using marijuana, cocaine and heroin. She entered a drug treatment facility but left the program within days and was no longer involved in drug treatment.

In 1997 she was hospitalized following a violent episode in which she physically attacked her grandaunt and other family members and was diagnosed with depression, post-traumatic stress disorder with major denial and avoidance and intermittent explosive disorder. The hospital recommended an outpatient program involving counseling and medication as well as follow-up with a community mental health organization. There is no record of this plan being implemented. The hospital's discharge plan also reported that the mother's placement with her grandaunt was not appropriate due to the caretaker's age and her inability to manage the teen mother.

The mother had at least eight reported incidents of violence, including two separate arrests for assault and battery against her grandaunt and a police officer. The private agency administering the teen parent program judged her home placement to be safe despite concerns about her explosive behavior. They based their decision on the mistaken belief the grandaunt was in her mid-fifties and the fact she had never indicated that she felt threatened by the mother. The grandaunt was actually in her mid-eighties and considerably less able to defend herself and the children against physical attacks. The OIG requested that a geriatric expert interview the grandaunt. The expert reported that the grandaunt understated the mother's violent behavior and substance abuse and was unrealistic regarding the mother's ability to parent. The grandaunt failed to grasp the significance of her advancing age as it related to her ability to provide a safe environment, adequate parenting and support for the two minors.

An Administrative Case Review report recommended that the three year-old be screened into court because of the mother's drug use and the grandaunt's advancing age. However, the private agency did not follow through with the recommendation because they believed the girl was safe in her current placement and her paternal grandmother had become involved in her care. The private agency's staff operated under the assumption that they could not intervene in the three year-old's care because she was not a ward. The paternal grandmother assumed responsibility for the three year-old's full-time care and is pursuing private guardianship. The mother did not sign a voluntary consent for guardianship. In order to construct an alternative care plan in the event the grandaunt was unable to care for the 10 year-old, the grandaunt's son was named the boy's co-guardian. The grandaunt's home was determined to be a safe placement because the mother ceased to reside there, although the grandaunt acknowledged the mother still makes weekly trips to the house.

Pregnant and Parenting teens are serviced through the Teen Parent Services Network (TPSN). Currently, when a case is transferred to TPSN, services are based only on new intake data compiled by TPSN. As such,

major continuing emotional or psychiatric problems can be missed. The President and Executive Director of the private agency agreed that when a case is transferred to TPSN, an initial reading of case records and development of a case chronology would help reduce fragmentation of information and provide a useful summary of important issues.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department needs to issue a directive to the Teen Parent Service Network to refer those pregnant and parenting wards with a history of major psychiatric or emotional problems that reside in home of relative foster care or traditional independent living programs to the Teen Parenting Assessment Team at the University of Illinois-Chicago. Once an adequate baseline on the problems of these special need teen parents is developed a more comprehensive service delivery system can be initiated and monitored.

The Department agreed.

2. The Teen Parent Service Network should incorporate a family systems approach with pregnant and parenting teens and their extended families.

The Department agreed.

3. TPSN should expand the Profile data system to include critical information for tracking purposes. Issues like substance abuse, mental health, mental retardation, violence, are a few examples

The Department agreed.

4. If the mother does not sign a voluntary consent for the three year-old's paternal grandmother to take guardianship within the next 30 days, the OIG will recommend that the child's case be screened into Juvenile Court for appointment of the grandmother as guardian.

The Department agreed. Guardianship was awarded to the paternal grandmother.

5. This report should be shared with the private agency's Director for future planning for program members.

The OIG shared this report with the private agency's Director.

6.This report should be shared with the Program Monitor.

The Inspector General and the Program Director met to discuss this report on October 30, 2000.

General Investigation 14

ALLEGATION

The mother of a one year-old boy left her son with his grandmother and did not return for two months. When the mother, who had three indicated reports against her and a history of disappearing, was located, the child was returned to her custody. At the behest of the judge presiding over the family case, the OIG was asked to investigate.

INVESTIGATION

The mother had four older children who were all in foster care as a result of the three indicated reports. The caseworker reported that the mother had little contact with her children or the agency before the birth of her fifth child. After the youngest child's birth, however, she began cooperating with services, successfully completing parenting classes and participating in drug testing and counseling. She also began visiting her four older children on a regular basis. The worker observed that the mother's home was in good condition and the one year-old was well cared for.

Prior to her disappearance, the woman asked her mother to take care of the boy for a few hours. When she did not return for several weeks and missed a court date a hotline call was made and a DCP investigator was assigned to the case. The DCP investigator conferred with the caseworker about the family history and eventually located the mother who was living with the boy's presumptive father. The investigator found the home to be appropriate and noted both parents agreed to leave the child with the paternal grandmother if necessary and to ensure that a care plan was in place if he would remain with the grandmother for an extended period.

The DCP investigator and caseworker agreed to allow the boy to return to his mother. However the criminal history check they initiated on the parents the day after meeting with them showed the mother had an outstanding warrant for prostitution. Between the time the meeting took place and when the results of the criminal history check were learned, the mother and child disappeared again. The father did not know their whereabouts but agreed to take the child if the mother returned to his home. The State's Attorney told the DCP investigator there were insufficient grounds to issue a Juvenile Arrest Warrant. The investigator indicated the case for inadequate supervision and closed the case. The mother later returned the child to his father who subsequently gave the boy to the paternal grandmother. The boy is still is his grandmother's care and services are being provided to the family.

The OIG determined that the DCP investigator acted responsibly in consulting with the caseworker and locating and meeting with the family to ensure the child's safety. Although the decision to allow the mother to regain custody of the boy is open to debate given her history, the OIG does not believe it rises to the level of wrongdoing.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The Department should explore the feasibility of developing a program that will provide full intact family services to non-custodial fathers who are not indicated for abuse or neglect and who express an interest in caring for their child(ren). This special intact family program could partner with the Paternal Involvement Project that currently provides adjunct services to fathers who want to be more involved in their children's lives. In addition to services already offered to intact families, this specialized program should:**

   - Establish a care plan for the child(ren), including day care, if needed;
   - Design a visitation plan for the mother; and
   -Ensure that both maternal and paternal relatives are included in permanency planning, if appropriate.

The Department agreed. Every opportunity should be made to encourage the non-custodial parent to be involved with the child, assuming the child's safety and well-being is assured. The Department has incorporated this recommendation into the Best Practice initiative.

General Investigation 15

ALLEGATION A woman complained to the OIG that her next-door neighbor, a DCFS mentor foster parent, was unable to control the adolescent boys placed in her home. The neighbor had previously made several complaints to police as well as other branches of the Department.

INVESTIGATION The OIG reviewed the histories of the three boys in the home, ages 13, 17, and 18. The two oldest boys, who are brothers, had been in Department custody for almost their entire lives. Their mother was a severe alcoholic and both boys were diagnosed with Fetal Alcohol Syndrome (FAS). This condition resulted in distractibility, impulsivity and deficits in the areas of abstract reasoning and social comprehension. Both boys exhibited non-verbal reasoning skills far superior to their verbal reasoning skills, which is also consistent with FAS. Therapists found the discrepancies contributed to the boys' poor performance in school. It was recommended that the boys receive additional training in developing their verbal and reading skills, utilize their visual learning abilities and gain membership in a local YMCA to participate in recreational activities as an outlet for their hyperactivity. While the school took steps to accommodate the boys' special needs, their caseworker had failed to secure a YMCA family membership.

The third boy was also taken into Department custody very early in his life and was placed in this foster home when he was nine years old. Although he had run away on more than one occasion and exhibited behavioral problems, he had a positive relationship with the foster mother and was much better behaved when he was engaged in regular therapy.

In April 1997, the foster mother's great-granddaughter, who had been living in the foster home with her mother, alleged that the oldest boy sexually molested her. The following month, a foster child who had previously lived in the home alleged that the same boy molested him. The boy disputed the claims and was supported by his foster mother and his caseworker at the time. While the investigation into these allegations was underway a Sexually Aggressive Children and Youth (SACY) protective plan was instituted as a precautionary measure and the boy was required to begin attending Juvenile Sex Offender (JSO) group treatment. The charges were later judged to be baseless and were unfounded, however the boy was still required to attend JSO sessions because of his SACY status. His intermittent attendance at these sessions became a point of contention between the treatment providers and the foster mother, who believed there were other issues that the therapist should address with the minor.

The foster mother had been licensed since 1985 and became a mentor foster parent at the program's inception in 1986. The Mentor Foster Home Program was designed to provide foster homes as an alternative to institutional settings placement for children with severe behavioral/emotional problems. Program staff consultants were Mentor consultants were available 24 hours a day, 7 days a week to provide support and assistance to the mentor foster parent. Specialized training for mentor foster parents was discontinued in 1994 and in 1998 the Department eliminated the 24-hour support services. The foster mother, who had run a group home for DCFS wards from 1990-1992, had consistently served as a viable placement option for the Department.

An OIG review of the foster home licensing file showed substandard recordings of licensing compliance reviews or complaint investigations. Portions of the file were known to be missing but no attempt had been made to reconstruct them. The licensing worker told OIG staff she was aware of her responsibility to complete annual licensing compliance forms but failed to do so, even though she visited the home on at least two occasions.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

Supportive Services

1. The Department should arrange for the two oldest boys to receive services from a leading child welfare specialist. This will include, but not be limited to, education for the boys, their foster mother, caseworkers and therapists who work with the boys on Fetal Alcohol Syndrome, its effects on behavior and learning and the implications for therapeutic techniques as well as ongoing consultation the foster mother and therapists.

The Department agreed. The case has been referred to the child welfare specialist.

2. The Department should amend it's contract with the private agency that previously provided therapy to the boys so that it will be the primary provider of therapeutic services for all three boys while they are wards of DCFS.

The Department agreed. The children are receiving in-home intensive services from the private agency.

3. The Department should ensure that the oldest boy is immediately linked to vocational training consistent with his strengths and stated interests, and that the middle child is linked to vocational training when it becomes appropriate. The Department should cover evaluation and training costs for both boys when they are not covered by other entities.

The Department agreed. The Division of Operations is working to ensure that these services are provided.

4. The Department should pay for the foster mother to have a family membership at the local YMCA.

The Department agreed. A YMCA membership is part of the service plan for the family.

5. The Department should ensure that the Vineland Adaptive Behavior Scale is administered to the two oldest boys. The evaluator should review the results with the foster mother, the caseworker, the evaluated child, and the therapy provider, and make recommendations regarding prioritized daily living skills needs. The Department should provide for an independent living skills trainer to work with each child for at least ten hours per week.

The Department agreed.

6. The youngest boy's paternal grandmother serves as a resource for the foster mother in the care of the child. However, given the foster mother's health problems and the paternal grandmother's difficulty dealing with the child's problem behaviors, the Department should prepare a back up care plan.

The Department agreed. A contingency plan for the care of the youngest boy was formulated.

7. The Department should provide transportation for the boys for all the aforementioned services when the foster mother is unable to do so.

The Department agreed. The Department will provide transportation for children when the foster mother is unable to do so.

8. The Department should ensure that each of the boys has a mentor approved through a formal

program like Big Brothers/Big Sisters.

The Department agreed. This recommendation was incorporated into the service plan for the family.

9. Arrangements should be made for the foster parent to receive regular respite services and stress management training.

The Department agreed. The concerns regarding stress and support for the foster parent will be met with comprehensive services, support and guidance from the field.

Program

10. The OIG previously recommended in OIG Case No. 97-1755 that the Mentor Foster Parent Program be strengthened and expanded and that the Department provide annual training for mentor foster parents. Specifically, training for the mentor program staff consultants and foster parents include, but not be limited to, behavior management techniques, Fetal Alcohol Syndrome, ADHD, and the use and purpose of psychotropic medication. The Department should clearly define the role of the mentor staff consultant and the relationship with caseworkers, and as well as ensure that mentor consultants are skilled in problem solving, service linkage and coordination, and understand adolescence, behavior problems, and mental health issues.

The Department is exploring the feasibility of this recommendation.

11. The Department should implement the diagnostic assessment network for failure-to-thrive as well as establish protocol for identifying the physical and behavioral indicators of failure-to-thrive and FAS to Healthworks primary care physicians and workers. This should include the characteristics of FAS over the life span.

In January 1999, the Department issued Policy Guide 99.2 dealing with second opinions for failure to thrive cases. The Policy Guide provided guidance as to when a second opinion for failure to thrive should be sought, and included a list of approved physicians and clinics for making referrals. The Department agrees to review and update the list as necessary; the Policy Guide will then be reissued with the current list.

In November 1999, the Department produced a videotape series for the Substance Affected Families Policy and Practice Training. This training includes information regarding Fetal Alcohol Syndrome (FAS). The Department began statewide training of DCFS and Purchase of Service (POS) caseworkers in November 1999. These videotapes were widely distributed, which enables the training to be provided to new staff in the future.

Employees

12. This report should be shared with the foster home licensing worker and her current supervisor so that the worker can be counseled regarding completing annual compliance forms, formally documenting contacts with foster parents, substitute caretaker background checks, and licensing investigations.

The Department agreed. The foster home licensing worker was counseled in regards to the above-mentioned items.

13. This report should be shared with the two oldest boys' caseworker and the supervisor so that the

caseworker can be counseled on timely linkage to services, problem solving, substitute caretaker background checks, and reading records as well as know the expectations for service provision for the two oldest boys.

The Department agreed. The caseworker was counseled in regards to the above-mentioned items.

14. This report should be shared with the youngest boy's caseworker and the supervisor so that the caseworker can be counseled on timely linkage to services and problem solving, as well as know the expectations for service provision for the boy.

The Department agreed. The caseworker resigned from the Department.

General Investigation 16

ALLEGATION

A DCP investigation resulted in a school teacher being indicated for physically abusing a student. The teacher charged that the investigator and her supervisors failed to conduct the investigation in accordance with Department Rules.

INVESTIGATION

The hotline received a call reporting the teacher had broken a student's hand by bending it backwards. The report also alleged the teacher had been physically and verbally abusive toward students in the past. The DCP investigator assigned to the incident learned the injury stemmed from the teacher's intervention in a physical altercation between two students in her classroom. The Department has very specific requirements, as dictated by statute, which govern DCP investigations of teachers. Prior to conducting her interview with the teacher, the investigator did not explain the steps involved in the investigative process or advise the teacher she could have a school administrator, union representative or attorney present at the meeting although Department Rules required her to do so. The investigator neglected to determine whether the teacher acted within the bounds of the local school board's rules regarding physical contact with students. The investigator also did not provide the teacher with a copy of the investigative file or offer her an opportunity to present contrary evidence before indicating the report, as required by Department rules. Once the decision was made to indicate the report, notice of the finding was delivered to the State Central Registry. Although the investigator recorded at that time that the school had been notified of the indicated report, no actual effort was made to inform the school until the investigator's supervisor wrote a letter to school administrators four days later.

The investigator and her supervisors blamed their errors in part on the investigator's inexperience conducting school-related investigations. The worker who had previously handled school investigations for their field office had left the Department, leaving other investigators to accept school-related cases on a rotating basis. The worker and her supervisors also cited inconsistencies between the applicable Department Rule and the corresponding Department Procedure. The Procedure portion of the manual had not been updated to reflect changes in the Rule.

The State Central Register (SCR) recorded dates in a manner unrelated to the actual dates of occurrences. In cases where investigators decided to indicate reports, SCR recorded the date of the finding as the day the investigator made a recommendation rather than the day the recommendation was approved. If subsequent events resulted in the decision being overturned, the same original date remained listed as the date the new determination was reached. Because of this practice, files did not accurately reflect when cases were indicated, although the Department is required to make such decisions within 60 days after allegations are reported.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Procedure regarding school employee investigations should be amended immediately to conform to the language of the corresponding Rule.

The Department agreed. Procedure 300.160(c) has been amended and sent out for comment.

2. The Department should provide training to each of its Child Protective Investigators concerning how to conduct investigations of school employees. Until such training is completed, the Department should ensure that all investigations of school employees are conducted by individuals familiar with the Rules and Procedures regarding investigations of school employees.

The Department agreed.

3. The Department should note the concerns indicated in this report and should instruct the State Central Register to properly record the date on which the State Central Register receives indicated findings. In the case of a school employee investigation, the date of the indicated finding should match the date on which the notices to the school district were mailed. The Department must also instruct SCR to notify the subject of an investigation about whether a report has been indicated or unfounded on a timely basis.

The Department is currently examining the process whereby SCR records dates of indicated or unfounded investigations.

4. The investigator's supervisors should be counseled for failing to review the investigative file properly or recognizing that the investigator did not comply with the Rule. The investigator should be required to attend a training session on conducting school investigations.

The Department agreed. Appropriate disciplinary action is being pursued.

General Investigation 17

ALLEGATION A Department caseworker assigned to provide services to a mother and her six children put the children at risk by placing two of them in a foster home with an adult sexual offender and two others in an abusive foster home. After the mother raised her concerns about the placements with the caseworker, he failed to take any action to investigate the charges. The complaint also alleged that the caseworker did not facilitate child-parent visits or arrange for counseling to be provided to the mother and her children even though it was called for in the service plan.

INVESTIGATION The five oldest children were taken into protective custody after the mother, who called 911 stating she needed help to care for the children, was indicated for abuse or neglect for the seventh time. The sixth child, born soon afterwards, was taken into custody at the hospital. The DCP investigator who first handled the case met with the mother's relatives and placed three of the children with relatives. The investigator decided not to place any children with another female relative because the woman vacillated on whether she wanted to accept them. Five days later, after the caseworker had assumed responsibility for the case, he instructed an intern under his supervision to place two of the remaining children with the woman the investigator had eliminated as a feasible option. The caseworker did not conduct background checks on the female relative's husband. The natural mother strongly objected to her children being placed in this home because of the husband's presence. She called the State Central Register (SCR) to report that the children were not safe because the husband had previously sexually abused his stepdaughter. The mother also relayed her concerns to the caseworker and a psychologist. The psychologist also called the caseworker to urge him to look into the allegation. A DCP investigator seeking to place two of the children's siblings with the same family conducted a criminal background (LEADS) check through SCR. The home was denied as a possible placement because the husband was shown to have a long criminal history. The children were subsequently removed from the home. The caseworker told the OIG that he did not recall conversations with the mother or her psychologist. He claimed he did conduct a LEADS check on the husband when the children were placed. He suggested the reason no criminal history was shown could have been because he gave the wrong spelling of the name or an incorrect birthdate. SCR records all LEADS requests, including the name of the requestor. No evidence that the caseworker ever requested a check could be found.

Two of the children were placed in another relative foster home. Again, background checks were not conducted. A LEADS check conducted by the OIG showed the father had previously been convicted for drug possession and distribution. The natural mother complained to the caseworker that the caretakers were physically abusing her children. On a later occasion when the mother had the children for the day, she observed whip marks on her two children as well as the foster couple's own child and called the hotline. The children told the DCP investigator the foster parents regularly whipped them with an extension cord and otherwise abused them. The children were immediately removed from the home. The caseworker did not complete an unusual incident report, record any case notes or include the DCP investigation in the case file.

The children were moved to another relative placement who reported to the caseworker that the children had emotional behavioral problems she felt ill-equipped to deal with and asked that the children receive counseling. The foster parent told the OIG that the caseworker repeatedly agreed to secure counseling services for the children but failed to follow through. The caseworker also neglected to make required visits to the home. The foster parent eventually asked that the children be removed because she could not control their behavior. The caseworker did not make any mention of the behavioral problems in his case notes and told his supervisor the children had to be moved because, "the placement just didn't work out."

The case record contained scant notation of parent child visits and evidence of multiple complaints by the mother regarding the lack of contact between she and her children. After a private agency assumed

responsibility for arranging visits, the mother visited her children regularly. The caseworker also did not request counseling for the mother until the case was with the Department for services. The Office of Quality Assurance reviewed the case file and rated its quality to be poor.

A review of the caseworker's history with the Department showed that he had previously been questioned about a discrepancy on his initial employment application. He had answered "no" to a question regarding being previously convicted of anything greater than a minor traffic violation. It was later learned that the caseworker had been convicted of misdemeanor assault and battery in another state. The caseworker claimed that he understood the question to pertain only to felonies and believed the conviction had been expunged from his record. The Department accepted the explanation and did not pursue discipline. The caseworker eventually resigned from the Department but later applied to be rehired. Posed with the same question pertaining to previous convictions, the caseworker again answered "no".

During the course of this investigation, the OIG became aware of inadequate service provided to the natural mother by a therapist contracted through the Department. Over a six month period, only five contacts with the natural mother were documented. On numerous occasions the therapist missed scheduled appointments or met only briefly with the mother. The therapist offered reasons for not meeting regularly that gave an appearance of unprofessional conduct. The Department should not contract with service providers that cannot demonstrate reliability and efficacy in their treatment services.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The caseworker should be disciplined for his failure to:

- **Conduct background checks on relative foster parents**
- **Facilitate parent/child visitation**
- **Respond to the natural mother's concerns about the safety of her children in the relative foster homes**
- **Refer the natural mother for counseling services in a timely manner**
- **Refer the two oldest boys for counseling**
- **Keep adequate records**
- **Monitor the foster homes**

In a separate charge, the caseworker should be discharged for falsification of his second employment application.

The Department agreed. Discipline for the caseworker has been initiated.

2. This report should be shared with Quality Assurance. The Department should focus its efforts on addressing service issues identified in this field office by the Quality Assurance Review. When Quality Assurance identifies serious deficiencies then Quality Assurance has an obligation to ensure that remedies have been implemented. Although, Quality Assurance has established guidelines to facilitate correction of casework insufficiencies, there was no indication that remedial corrections were attempted for identified deficiencies in this case. Subsequent to Quality Assurance reviews, supervisors should document that they reviewed the findings with the supervisee and that issues were addressed. Likewise, managers should document measures taken to address team related deficiencies.

The Department agreed. The report was shared with Quality Assurance. Quality Assurance and the Division of Operations are working to implement this recommendation.

3. The caseworker's current supervisor should be made aware of performance issues identified by Quality Assurance and the OIG to alert the supervisor to closely monitor his work and to assist the

supervisor to address those issues in supervision.

The Department agreed. The caseworker's current supervisor has been made aware of his performance issues.

4. The Department should review their contract with the therapist and evaluate the reliability of her therapeutic services.

The Department agreed. A review of the contract will be conducted.

General Investigation 18

ALLEGATION A one year-old boy was taken into Department custody after his mother, a former ward, reported she was unable to care for him. Prior to the department taking custody, the child stayed with a high-ranking Department administrator who knew the boy and his mother through the mother's former foster parent, a member of the administrator's staff. The OIG was asked to investigate possible conflicts of interest regarding the involvement of the administrator and the former foster parent in this case.

INVESTIGATION The natural mother called the hotline to report she was unable to care for her son at the urging of her former foster parent, who had been a DCP investigator at the time the mother was in her care. The mother had previously surrendered parental rights to her two older children, who had since been adopted. The mother agreed to place the one year-old with the Department administrator while she received child welfare services but soon afterwards informed the administrator she wanted to renounce custody of her son. The administrator knew the mother as a former foster child and knew the mother had been diagnosed with bi-polar disorder. The administrator then asked a close relative who held an administrative position in state government if she knew anyone interested in adopting an infant. The relative knew of a co-worker and his wife who were looking to adopt an infant and they arranged for the wife to meet the child. On the day the meeting was to take place, the natural mother called the administrator to say she had changed her mind but was told by the administrator the prospective adoptive mother was already on her way to the home. Both the natural mother's caseworker and former foster parent told the OIG the mother was extremely upset that potential adoptive parents were already visiting her son and believed the Department hierarchy was taking her son away from her and excluding her from having any role in decision-making regarding the boy's future. The administrator told the OIG he did not believe keeping the child out of the system and then offering the opportunity to adopt him to a state employee was inappropriate.

The natural mother vacillated but ultimately decided to retain custody of her son. She signed a voluntary placement agreement, sending the infant to live with a licensed foster family for 30 days while she received intensive services. During this time, the former foster parent obtained temporary guardianship of the child in probate court. The boy was returned to his mother after she completed services. Soon afterwards, however, the mother, who was diagnosed with Bipolar Disorder, stopped taking her medication and refused medical attention for her son who was suffering from an ear infection. A hotline report was made for lack of compliance and medical neglect and an investigation was opened. The mother signed a second voluntary placement agreement, placing her son with another licensed foster parent. The former foster parent was concerned the infant would be taken into protective custody if further problems arose so the former foster parent, the mother and the assigned DCP investigator decided the mother would terminate the temporary placement agreement and transfer custody to her former foster parent.

The former foster parent was familiar with the foster parent who cared for the child under the second voluntary placement agreement through their involvement in child welfare. The former foster parent with whom the child was now placed asked the other foster parent to baby-sit the boy while the former foster parent went out of town for two weeks. The voluntary placement agreement granting custody to the former foster parent was set to expire while he was away. Fearful the Department would take protective custody of the boy once the agreement expired, the former foster parent terminated the agreement before he departed and left the boy with the other foster parent. While the former foster parent was away, the child developed an ear infection. The foster parent called a hospital and was told the child could not be treated without the consent of a parent or guardian. The foster parent then called the DCP investigator who in turn contacted the hotline prompting the Department to take the infant into protective custody. Allegations of inadequate supervision and medical neglect were investigated against both the natural mother and the former foster parent. The natural mother was subsequently indicated for inadequate supervision.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The Director of the Department of Children & Family Services should direct a letter to the Department administrator, a copy of which should be maintained in his personnel file, stating that he is to notify his supervisor prior to having any private involvement with any children or families who have had any prior involvement with the Department of Children and Family Services within the last twelve months. The supervisor will then seek an Ethics Opinion from the Department's Conflict of Interest Panel concerning the propriety of any such involvement.**

The Department agreed. A letter was sent to the administrator on June 28, 2000.

2. The private agency that the former foster parent is licensed through should receive a copy of this report. The agency should meet with the former foster parent to delineate boundaries and otherwise ensure that in the future he will be in a better position to avoid situations in which his private life may come in contact with his professional life.

The Department agreed.

General Investigation 19

ALLEGATION The mother of a five month-old girl was the subject of a hotline report alleging child neglect due to substance abuse. The DCP investigator assigned to the case discounted accusations of drug use and intended to unfound the report. Three weeks later, the five month-old was found alone in the basement of an abandoned building. When the mother was apprehended she was in possession of drug paraphernalia and told police she left the child while she went a few doors down to prostitute herself to earn money for crack cocaine.

INVESTIGATION The initial hotline report was registered after the mother encountered police on the street and told them that she and her child were homeless. Police took the two to the station where the mother fell asleep while holding the baby and could not be awakened. Once police did manage to rouse the mother they removed the baby from her arms, at which point she became violent and began shouting unintelligibly. The mother was arrested and a relative came to the station to pick up the child. At the time the hotline report was accepted, the case was referred to the Division of Child Protection (DCP) but neither the State Central Register (SCR) nor the DCP investigator conducted a criminal background check as required by Department regulations. The child protection investigation, however, was still open at the time of the second hotline call.

The DCP investigator interviewed the mother who told him she became upset when she awoke to find police officers taking her baby and was defending her child. She stated that she was staying at her godmother's house overnight and would seek placement in a shelter the next day. The investigator observed the child to be healthy and found no signs of abuse or neglect. The next day the mother called the investigator and told him the Department of Human Services had placed her in a shelter. The investigator did not call the shelter to confirm the mother's presence. The investigator subsequently left on vacation with the intent of unfounding the report upon his return. Before he returned to work, a second hotline report concerning the family was made, alleging the child had been found alone in an abandoned building. He learned of the second report on the radio the morning of his first day back at work.

In an interview with the OIG, the investigator said he did not believe the mother was a drug user based on his contact with her, the fact that the baby was not born drug exposed and was healthy with no signs of abuse or neglect. He also said he interviewed the woman's godmother and an acquaintance who both told him she was not on drugs, although he did not record these contacts in his case notes. The investigator said he "gave weight" to the police suspicions of drug use but believed the homeless, single mother could have fallen asleep at the station because of fatigue and would have been understandably upset awakening to find officers taking her baby. The investigator said that after speaking to the mother he did not feel a CANTS/LEADS check was immediately necessary. Background checks conducted following the mother's arrest for abandoning her child found she had an extensive criminal history including arrests for prostitution and drug possession. The investigator told the OIG that he had experience evaluating situations involving substance users but, in this case, "he was fooled."

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The DCP investigator should be counseled to address his failure to conduct a proper initial investigation and his failure to adequately assess the potential risks to this child. He should also be counseled regarding the need to adequately and accurately document his investigative steps.

The Department agreed. Appropriate disciplinary action is being pursued.

2.The SCR call floor worker should be counseled about complying with the LEADS protocol.

The Department agreed. Appropriate disciplinary action is being pursued.

3. As the Inspector General has previously recommended, the LEADS protocol and Adult Substance Abuse Screen should be modified. Where drug use is an issue in an investigation, a LEADS check should be required to verify the accuracy of a "No" answer to the items: "Drug or drug-related criminal charges", "Non-drug related charges" and "Have you ever been charged with Driving Under the Influence?"

The Department implemented Policy Guide 99.13, Services for DCFS Substance Affected Families, on December 1, 1999. The policy states that a LEADS check must be performed to verify any "no" responses to the screening questions on drug or drug-related criminal charges, non-drug related criminal charges, and DUI charges.

General Investigation 20

ALLEGATION A 10 year-old girl with cerebral palsy and scoliosis was placed in the foster home of a 69 year-old woman with a criminal history. The OIG was asked to investigate the caregiver's background and assess whether it would be appropriate for her to adopt the child.

INVESTIGATION The child was initially placed in the home in November 1993 because her previous relative caretaker could not attend to her extensive health care needs. She is only able to walk with the use of equipment or physical assistance and has been receiving outpatient physical therapy for the past six years to improve her mobility.

School personnel reported that her progress at school is more significant than what the foster mother reports she is capable of doing in the home. School personnel related to the OIG that the girl wore underwear to school but told them she wore diapers at home. They feel she responds positively to challenging situations but regresses at home where less is required of her. On one occasion she attempted to move through the classroom by crawling. When told by staff this was unacceptable, the girl told them she often crawled to get around her house. OIG staff observed the girl crawl up the front steps into the home during an interview with the foster mother. Although it was learned through contact with United Cerebral Palsy that crawling may sometimes be the safest way for a disabled child to get around, the foster mother had never been informed of such by her licensing agency nor had her caseworkers discussed with her the possibility of acquiring adaptive equipment for the home.

The girl is afforded no opportunity to observe or interact with other children with disabilities. She is the only disabled child in her school and does not participate in any outside activities geared towards disabled youth. The foster mother said that she has not asked for any help from her caseworker nor has she requested any assistance in locating recreational resources for disabled youth.

The foster mother is unemployed and does not receive a pension. Her only source of income is $300 a month in social security. She receives approximately $3000 per month from the state for the foster children in her care. The foster mother has been arrested eight times, as recently as October 1997, and has four convictions. She told the OIG that aside from the 1997 incident, which she claimed was a mistake, she could not recall the circumstances that led to her other arrests. The foster mother's background was waived by the licensing agency and the Department.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The foster mother should not be permitted to adopt the child. Long term foster care in the home is preferable in order for the Department to monitor the girl's care and ensure that her needs are met in the foreseeable future. This living arrangement will allow the girl and her biological sister to remain together. Long-term foster care is recommended with the following conditions:

A. In order for the girl to continue living in the home, the foster mother must cooperate with the Department in terms of accepting services and meeting expectations that will address the child's needs:

a. A home care assistant be permanently assigned to the girl's home to ensure that she:

- attends all medical and dental appointments
- bathes daily

- does physical therapy exercises at home with assistance
- participates in toilet training that is effective with children with similar disabilities

b. The home is assessed to determine reasonable accommodation requirements and ensure implementation of recommended modifications.

c. The girl's equipment needs be assessed and met.

B. Occupational therapy and other activities suggested in this report, i.e., enrollment in an after school or recreational program with children and adults with disabilities, summer camp that serves children with disabilities, should be immediately advocated. If occupational therapy services are not covered by medicaid at this time, the Department should arrange for reimbursement of services.

C. The foster mother must submit to a comprehensive health examination and consent to release of information to the Department.

The Department agreed that the girl should remain in the home, but believes that permanency can be achieved in this home. The girl is well integrated in the home and is emotionally attached to the members of the family. The girl has indicated a desire to be adopted by the foster mother and to remain in the home with her biological sister who has been adopted by the foster mother.

The foster mother's home has been assessed to determine reasonable accommodation requirements for the girl and the required equipment, including ramps, has been ordered and will be provided to support this placement.

2. Assess the foster mother's family, namely her son and her granddaughter, to determine their potential as caregivers should she be unable to meet her parental responsibilities.

The Department agreed, notwithstanding that DCFS believes that the foster mother can become a permanent placement. An assessment of the family has been completed. The foster mother's son and his wife have agreed to care for the girl and the other children in the foster mother's care should she be unable to meet her parental responsibilities.

3. The Department should collaborate with agencies that serve persons with disabilities for training purposes and to develop a user friendly assessment tool for determining accommodation requirements of a foster home and foster parent in relation to the needs of the foster child with disabilities. Periodic use of an assessment tool would be useful during the child's growth and development to capture changing needs.

The Clinical Division has developed a questionnaire to assist caseworkers and foster families in determining home adaptation needs. The Clinical Division is also working with the Division of Training to develop a training curriculum for child welfare staff serving families with disabilities. It is expected that the curriculum will be ready in FY 2001.

4. The Department should thoroughly evaluate the other foster child in the home to determine what needs should be addressed. The child is reported to have behavior problems both in the home and school. She is in special education, has asthma and requires the use of a nebulizer. She was reported to

have been sexually abused by her father.

The Department agreed. An evaluation has been completed. The foster mother has subsidized guardianship of the girl and the child appears to be stable and progressing in school.

5. The Department should evaluate and determine whether the private agency truly has the capability to operate a specialized treatment foster care program and, if so, assist the agency in program and personnel development in order to adequately meet both short and long term needs of the children served by the program.

The Department agreed. The private agency's service capacity is currently being evaluated by the Department.

General Investigation 21

ALLEGATION

A 19 year-old girl whose family had ongoing involvement with the Department wrote a letter to a Department Administrator complaining about a small counseling agency involved with her case, singling out the agency's Executive Director. The Executive Director responded by writing a mean-spirited letter to the Department Administrator that was harshly critical of the girl and forwarded a copy of the letter to the 19 year-old.

INVESTIGATION

The girl and her 17 year-old brother had written letters complaining about limitations placed on sibling visitations between the five children in the family and restrictions on contact between the children and their parents. A review of the case record showed a history of extreme family dysfunction including multiple incidents of physical and emotional abuse, neglect and incest. The three youngest children had been placed in separate foster home placements while the 17 year-old lived in a group home. The 19 year-old had gone away to college. The issues regarding visitation had been brought before the court and independent evaluations of all the family members were being conducted. The Department's Clinical Division had also become involved in the case.

The two older siblings had concerns regarding the private agency caseworker assigned to provide services to the family, particularly the three youngest children. The 19 year-old's letter to the Department Administrator complained about the private agency and the agency's Executive Director, who had personally conducted therapy sessions with the girl. The Executive Director saw a copy of the letter and wrote a response to the Department Administrator. In her letter, the Executive Director berates the girl's character, cites her past incestuous behavior as reason to impeach her credibility, claims the girl has lied repeatedly in order to "set people up" and suggests that she is only acting as a proxy for her parents to manipulate the Department. The letter is decidedly unprofessional considering the Executive Director's status as a treatment provider directly involved with the family and the personal nature of her remarks regarding the 19 year-old. The Executive Director of a treatment agency should be able to accept criticism or unfavorable comments from a young client without feeling obliged to retaliate.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The Department should cease contracting with the private agency. Department wards should not be subject to treatment by an agency and Executive Director that demonstrates so little ability to deal with adversity.**

The Department is currently reviewing all contracts and associations with the private agency.

General Investigation 22

ALLEGATION A private agency caseworker complained that a DCFS program manager had signed the caseworker's name to three separate case transfer forms. The caseworker was unaware the cases had been transferred to her until just before she was found by the court to have made no reasonable effort to provide services.

INVESTIGATION The cases involved three children who were living in a temporary shelter placement with the caseworker's agency. The DCFS program manager was informed by the caseworker's supervisor that the children had been accepted into independent living but the agency could not yet accept formal transfer of the cases until certain bureaucratic details were finalized.

In April 1999, the DCFS program manger received a report from a DCFS administrator questioning why children who were supposed to be moved into independent living were still in shelter care. The program manger recognized the three cases and contacted the private agency. The private agency supervisor's assistant supplied the program manager with the necessary transfer information and gave her the caseworker's name as the individual who would be accepting the cases. In the interest of accelerating the transfer process, the program manager signed the caseworker's name to the required forms and faxed them to her as well as entering the caseworker's name into the Child and Youth-Centered Information System (CYCIS) database, which is designed to provide pertinent and historical case information, as the assigned worker.

Four months later the caseworker received change of status forms for the three cases via fax. She contacted the program manger and told her she did not have all the information required to accept the cases. She also informed her supervisor that her name had been signed to the transfer documents by the DCFS program manager. The program manager's supervisor instructed her not to sign anyone's name to documents under any circumstances. The court's finding that no reasonable effort had been made by the private agency in providing services to the family was based on the time that had passed since the caseworker's name was entered into the CYCIS database.

On a separate occasion, the program manager was counseled by her supervisor as to the inappropriateness of entering unconfirmed information into CYCIS. Because the program manager was leaving her position and would no longer be able to make changes in CYCIS, her supervisor decided it was unnecessary to include the incident in the program manager's personnel file.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The counseling session that addressed the false entry of CYCIS information only must be documented and reflected in the program manager's personnel file.

The Department agreed. A counseling session was held with the program manager on September 30, 1999.

2. The program manager must be disciplined for signing the name of another caseworker without permission and against Department procedure.

An administrative meeting was held with the program manager and appropriate discipline is being pursued.

General Investigation 23

ALLEGATION The caseworker assigned to a teen mother's case did not investigate charges that one of the mother's children was sexually abused while in foster care and failed to adequately assess a foster home the mother and her children were placed in. The complaint also alleged the caseworker became romantically involved with the teen parent's mother.

INVESTIGATION After both the teen mother and the teen's mother were the subjects of indicated child abuse/neglect reports, the teen mother and her children were removed from the maternal grandmother's home and placed with the paternal grandmother of the teen mother's youngest child. The mother and her three children were placed in the home under an order of protection directed to the paternal grandmother and her 24 year-old son, the father of the youngest child. While in the home, the teen mother was again impregnated by the 24 year-old. The mother and her children were removed after an incident in which the 24 year-old hit her in front of her children; however she and two of her children were later returned to the home. The third child remained with the paternal grandmother of her other children.

The Department then transferred the teen mother's case, along with a number of other cases, to a private agency. The private agency caseworker assigned to the case told the OIG he selected the case because he thought it looked "easy", a simple matter of getting the third child returned home. The caseworker saw the limited space in the foster home as the only problem with the teen mother's placement. After the time the case was transferred, the teen mother became pregnant with another child. The caseworker was unaware of several developments in the history of the case, including the incident where the 24 year-old slapped the teen mother, despite the fact the incidents were documented in the case file which was in his possession. The caseworker also failed to provide services to the teen mother's brother after his case was transferred to him even though he acknowledged accepting the case.

The caseworker then transferred the teen mother and her two children to an independent living program administered by another private agency. However, several workers reported they believed the teen mother was unprepared for the responsibility. One month after the teen mother moved in she started a grease fire on her stove and burned the apartment down. The caseworker thought his involvement with the case ended when the mother entered the independent living program and only became aware he was still responsible for providing services after being informed by the court several months after the teen mother had been moved. The caseworker never addressed the concerns raised by other workers about the mother's suitability for the program. The caseworker never referred the mother for individual and family counseling as recommended in a psychological report, resulting in a court determination that he had made no reasonable effort to provide services. A review of his history showed that the caseworker had a poor record of complying with court orders and attending court hearings.

While the teen mother remained in the independent living program she became pregnant with her sixth child and her third child was returned to her custody. After she was returned home it was discovered through a physical examination that this child had been sexually abused. Because the girl had recently been in several different placements, investigators were unable to determine the perpetrator of the abuse . The teen mother stated she had told the caseworker about the sexual abuse but that he did not act on these allegations. After hospital staff who treated the abused girl determined that her mother would not be able to provide the necessary care, the court intervened. The girl was removed from her mother's home and placed in specialized foster care. The teen mother's children were still in her custody but under an order of protection. The court warned the mother that if she violated this order her children would be removed. A few weeks later, the teen mother's landlady found the three youngest children home alone. The report was indicated for lack of supervision and all five remaining children were taken into protective custody and placed in foster care.

In addition to the concerns regarding the caseworker's handling of the family case, the OIG investigated allegations that he had become romantically with the teen parent's mother. Another child welfare professional involved with the family told the OIG that on one occasion, the caseworker was late arriving to transport one of the teen mother's children and could not be located. The teen mother told another worker she could locate him because he was having an affair with her mother. When questioned by the OIG, the caseworker offered conflicting statements regarding his contact with the grandmother and the frequency of his visits to her house. Both the caseworker and the grandmother denied any romantic involvement.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The Department should ascertain the caseworker's current employment status. His behavior during this case and throughout the Inspector General's interviews reflect his poor judgment and attitudes toward his responsibilities in child welfare.**

The caseworker is not currently employed by the Department.

2. In light of the facts presented in this report, the private agency should talk to the foster mother about the improprieties that appeared to take place in her home.

The Department agreed.

3. The facts of this case should be shared with the teen mother's current service providers.

The Department agreed. Portions of the report were shared with the teen mother's current service providers.

General Investigation 24

ALLEGATION

A couple alleged that the two foster daughters they hoped to adopt had been removed from their home by the private agency that placed them as retaliation for complaints the couple made regarding a lack of services provided by the agency. The couple also believed the agency opposed the adoption because the foster parents are of a different race than the children.

INVESTIGATION

The licensing representative for the private agency that licensed the couple had concerns about the home from the beginning. The couple had very particular requests as to what children they would be willing to accept and displayed an apparent inability to work as part of a team. A second agency approached the couple about accepting children and placed two sisters with them, ages seven and nine. During the three months the girls were in the home, workers from the private agency that placed the girls documented a pattern of inappropriate behavior exhibited by the foster parents towards the children. The foster father was often involved in heated, personal arguments with the girls which elicited extreme reactions from him. He told a caseworker that after one argument with the younger girl he sat and cried because she had hurt his feelings. During another he told the older girl he was going to "put an egg up her butt" while she was sleeping. The foster father told workers on multiple occasions he believed the younger girl's behavioral problems were the result of "a demon inside her" and the couple repeatedly told the girls they were going to "trade them in" for children they saw behaving politely in public. The couple was consistently inappropriate in their verbal and physical treatment of the girls, who told workers they were scared of their foster parents. The couple eventually decided to end the placement and the agency recorded their request to have the children removed. After the sisters were removed from the home, the foster father told a worker he hoped the girls, "were miserable in their new placement and were crying and upset."

The OIG investigation into this case found no evidence of retaliation against the foster parents by the private agency.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

The couple's foster home license should be revoked.

The Department agreed. The couple's foster home license has been put on hold and revocation is being explored.

General Investigation 25

ALLEGATION Two sisters, ages eight and five, reported they had been sexually abused by their former foster parents' 14 year-old son. The assigned DCP investigator indicated the report against the 14 year-old without informing the foster family he was conducting an investigation or interviewing their son, the alleged perpetrator.

INVESTIGATION Eight months after the sisters were removed from the foster home at the parents request, the girls' therapist reported the older sister told her of the abuse during a therapy session. The information was forwarded to both DCP and local law enforcement. The DCP investigator deferred to the police's desire to assume the lead role in the investigation and refrained from interviewing the alleged perpetrator, instead conducting collateral interviews. The police arranged for a Victim Sensitive Interview (VSI) to be held with the sisters on a date the investigator was required to participate in a mandatory Department training. Neither the investigator nor his supervisor secured a substitute investigator to be present at the VSI. Following the VSI, a child therapist deemed the allegations of sexual abuse credible. The 14 year-old's parents refused to allow police to question their son but never expressly stated the DCP investigator could not do so. The officer heading the criminal investigation told the DCP investigator that he believed the boy should be charged based on the information gathered in the VSI but the case was suspended pending a police interview with the boy. The DCP investigator decided to indicate the report based on the officer's conclusion.

The investigator's supervisor stated she approved the indicated finding based on the investigator's recommendation but expressed a misunderstanding of Department regulations regarding interviewing alleged perpetrators. Although Department regulations provide for delegating interviewing responsibilities to other agencies, such requests must be made formally and the investigator must provide explicit questions to be asked on behalf of DCFS. The investigator acknowledged to the OIG that he should not have indicated the report based on the foster family's refusal to cooperate with the criminal investigation and said he "dropped the ball" in regard to his work on this case.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The investigator should be counseled about his failure to interview the alleged perpetrator. His actions in admitting his failures in this investigation indicate that he has recognized that he made an error. He should be admonished that this is an inappropriate investigative practice.**

The Department agreed. The investigator was counseled on October 12, 2000.

2. **The investigator's supervisor should be counseled about conducting proper reviews of case notes and about the procedures for delegating investigations.**

The Department agreed. The supervisor was counseled on October 12, 2000.

3. **Licensing should do a complete assessment of the former foster home. The goal of this assessment should be to determine if the home is appropriate for the placement of children age 14 and younger.**

The Department agreed.

General Investigation 26

ALLEGATION A hotline call alleged that a professional couple was keeping their 12 year-old adopted son confined in an unfinished basement bathroom. The couple complained that the assigned Child Protection Investigator and his supervisor acted dishonestly by initially telling them that the case would be unfounded but later returning an indicated finding. They also believed the workers should have assisted them in securing residential placement for their son who they felt was beyond their control.

INVESTIGATION The 12 year-old told a police officer that had come to his school that his parents kept him locked in an unfinished bathroom in the basement of their home. The officer spoke with the boy's father who confirmed that he and his wife kept the boy locked in the basement bathroom as a punishment for his behavior. For several months he was only allowed out for school, meals and chores. The officer went to the home and inspected the bathroom, which he noted as being small, cold and damp with an unpleasant odor. The father also told him he locked the door to his two year-old son's room at night to prevent him from wandering around the house. Following the visit, the officer called the hotline to report the confinement.

The DCP investigator and her supervisor interviewed the parents in the office of their attorney. They reached an agreement with the couple stating that the 12 year-old would no longer be kept in the basement, the locks would be removed from the two year-old's door, matters involving serious behavioral problems would be referred to the police and counseling would be sought for the 12 year-old. Two days later, the DCP investigator visited the home for the first time. The investigator stated in a deposition she wanted to take protective custody of the boy upon seeing the home but was dissuaded by her supervisor. The supervisor stated he instructed the investigator not to take protective custody because of the agreement that had been reached with the parents and also as a matter of "professional courtesy" to the father, a pediatrician. A month later, the case was screened into court and the 12 year-old became a ward following a no-fault dependency hearing. The boy was subsequently placed in residential foster care.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **The supervisor should be counseled with regard to how he acted in the case. He should understand that "professional courtesy" does not exist for the Department when the safety of children is involved. He should understand that the agreement he made with the parents and their attorney was not proper when made prior to a full awareness of the circumstances.**

The Department agreed. The Associate Deputy Director for Child Protection spoke to the supervisor at length regarding this incident. The supervisor has changed positions within the Department and the report will be shared with his current supervisor.

2. **Workers should be made aware that when they do not agree with their supervisor on a substantive issue with strong ethical implications, they can ask the Office of the Inspector General for an ethical consultation as to how to proceed.**

The Department agreed. The Department will issue an information transmittal on the proper course of action for addressing this type of situation.

General Investigation 27

ALLEGATION

A 17 year-old woman boarded a bus carrying her infant son when the driver noticed that the baby's breathing was labored. The driver observed that the baby was bruised, bleeding and vomiting and summoned police and paramedics who took the mother and her child to the hospital. The baby suffered from a possible skull fracture, lacerations on the chin, retinal damage caused by shaking, fractures to the left and right forearms and bruising to the eyes and ears. He had scabs, scarring and bruising throughout his entire body, a temperature of 106 degrees, appeared malnourished and had sores in his mouth.

INVESTIGATION

The family first became involved with the Department in 1996 when the girl's father was indicated for abuse after punching her 15 year-old brother in the eye for smoking marijuana. A subsequent investigation following another indicated report revealed the father had 22 arrests for a variety of offenses including domestic violence, criminal sexual abuse, battery, burglary and violating orders of protection on his wife and children. The father was a severe alcoholic who had spent time in court ordered rehabilitation because of DUI charges. He experienced auditory and visual hallucinations and had a diagnosed heart condition as well as cirrhosis of the liver. His wife's IQ registered as borderline mildly mentally retarded. All four of the children had learning disabilities and were involved in special education.

The family was referred for Intact Family Services. The assigned worker noted the goal of keeping the family together was "unrealistic". The homemaker assigned to provide services to the family told the caseworker that the family's disinterest in participating in any constructive manner prevented any progress from being made. The homemaker stated that no one in the home showed any initiative in caring for the 17 year-old's baby.

In August 1998, the worker wrote that the family had received all possible assistance from the Department. She indicated that the family should be transferred to a full service mental health center for treatment and services. The worker and her supervisor referred the family to a private treatment agency, however the agency declined to accept the family because, "of the size of the family and the seriousness of mental health problems." The worker and her supervisor tried a second time to have the agency accept the case, but the agency again declined.

While working as a day laborer, the couple's oldest son was sexually attacked by an adult male co-worker. The boy was subsequently diagnosed with rectal chlamydia and was hospitalized for depression and suicidal ideation.

Following a violent, knife-throwing argument between the 17 year-old and her mother, the father attempted suicide. The next day the mother was hospitalized after suffering an apparent nervous breakdown. The children were relocated to residential placements. Soon after entering another placement facility, the 17 year-old took her son and ran away with her boyfriend. She had no contact with the Department until the incident on the bus.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. **DCP's Intact Family Service program should develop criteria for assessing the families that are appropriate for its services. Strict guidelines need to be put in place that would prevent a family from being considered for the Intact Family Services program when there are severe mental health problems, addiction, domestic violence, sexual abuse, and criminality in addition to child welfare issues.**

The Department agreed. A Family Preservation Committee has been formed to look at all facets of intact family services and family preservation. The committee will address the issues identified in this recommendation.

2. When a teen parent, whose family's case is being screened into court, has demonstrated inappropriate and lax parental behavior with their own child that rises to the level of a safety risk, DCP should also screen the child's case into court and request an order of protection. The order of protection will provide a measure of safety for the child and some structure for the teen parent.

The Department agreed.

General Investigation 28

ALLEGATION The maternal grandmother of a one year-old boy alleged the DCP investigation that resulted in an indicated finding against her daughter, the boy's mother, was based on "nothing but lies" and that the private agency handling the family's case had acted improperly in several instances.

INVESTIGATION The indicated report against the natural mother stemmed from an incident in which a babysitter saw the mother choke her son and hit him over the head repeatedly with a remote control. The mother, who has been diagnosed as mentally ill, was apprehended by police and taken to a psychiatric hospital. The OIG found the DCP investigation of the allegation was handled properly and there was ample evidence to merit indicating the report.

Following the mother's hospitalization, the boy was placed with his maternal grandmother. A supervisor from the private agency later called the hotline to report a number of safety concerns in the home including unexplained injuries to the child, irresponsible child care practices and improper caretakers being left to supervise the boy. As a result of the agency's intervention, the child was removed and placed in a traditional foster home. The maternal grandmother appealed the decision and contacted the Department's Advocacy Office because she believed that the private agency committed misconduct while handling the case. The OIG found that, in fact, the private agency went to great lengths to provide assistance to the family. However family members were consistently disruptive and non-compliant, failing to appear at scheduled meetings and abusing each other both verbally and physically when they did attend.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The OIG has discussed with the private agency another referral for the natural mother to a parenting assessment team. The agency has agreed to re-refer the mother; however this is impossible without signed consents from the mother. The mother, however, is incompetent and the maternal grandmother is her guardian. The private agency will thoroughly explain the consequences of not signing consents to the maternal grandmother and document their efforts.

The Department agreed.

2. The Advocacy Office should cease advocating on the maternal grandmother's behalf and this report should be shared with the involved Advocacy Office worker.

The Department agreed. The report was shared with the worker.

General Investigation 29

ALLEGATION

A two year-old girl was taken to an emergency room by her parents with unexplained bruises. A complaint was filed with the OIG alleging the abuse and neglect report against the parents had been unfounded despite two doctors' conclusions the bruises were caused by abuse. The complaint also claimed the initial hotline report had been improperly altered to exclude the parents as possible perpetrators and that several local police officers were present at the hospital "on behalf" of the father, a fellow police officer, after the child was brought in.

INVESTIGATION

A review of Department records showed the DCP investigation of the incident resulted in an indicated finding against the parents. The SCR worker who took the hotline call told the OIG he initially listed both the parents and the child's day care center as possible perpetrators, but removed the parents names after receiving information that the parents had been ruled out. At one point during the course of her investigation, the DCP investigator told one of the doctors who suspected abuse to call the hotline. It is better practice for child welfare professionals to respond proactively in these situations by making hotline calls themselves to ensure proper action is taken. There was no evidence suggesting the police officers attempted to exert any influence over hospital staff.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

This report should be shared with the DCP investigator and her supervisor.

The Department agreed. The report was shared with the caseworker and her supervisor.

General Investigation 30

ALLEGATION

The OIG received information indicating that an employee may have been involved in the abduction of her nieces from the home of their father and stepmother.

INVESTIGATION

The father of three daughters had been widowed a few years prior and had recently remarried. The maternal relatives felt the stepmother was trying to alienate the girls from them and turn them against their father. Soon after they were married, the stepmother learned the father was a drug abuser and compulsive gambler, leaving the family in a precarious financial situation. The stepmother made a hotline call to report that there was no food in the house. The DCP investigator assigned to the case met with the girls, who appeared well and behaved appropriately, and found there was an adequate amount of food in the home.

The girls' aunt, a Department employee, called the DCP investigator to report that she had witnessed the stepmother, a licensed foster parent, yelling at a young foster child placed with her. The employee also told the investigator her beliefs that the stepmother was a negative influence in the family. The DCP investigator advised the employee to see if the father would allow the girls to live with their relatives. She also faxed her an "Agreement for Protective Plan" document the father could sign to transfer temporary custody though she advised her the form would have to be notarized before it was valid. The employee faxed the document to another sister who took it to her brother's house, had him sign it and left with the two youngest children. When relatives arrived later to take custody of the third child, the stepmother was present in the home and called the police. The officers informed the relatives the form was invalid and the father, who by this time had reconsidered his decision, wanted his daughters returned. The relatives complied and brought the girls back the next day. Sometime later, the stepmother made another hotline call alleging physical abuse by the father against one of the girls. The same DCP investigator was assigned to the case. During the second investigation she encountered Illinois State Police who were investigating the Department employee and informed the investigator for the first time about the misuse of the Protective Plan form.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The form, "Agreement for Protective Plan" is not an official DCFS form and its use should be limited to those situations where a DCP investigator believes that it would be best for children to be temporarily removed during an investigation while a determination is made regarding protective custody. The DCP investigator should directly make the arrangement for such temporary placement when necessary. The form should never be used as a matter of convenience among family members because of the official tone contained in the form, as it was in this case.

The Department agreed. As part of the Child Endangerment Risk Assessment Protocol (CERAP), a form that will document safety plans is being revised through the Best Practice initiative.

2. The DCP investigator should be counseled for improperly using the Agreement form.

The Department agreed. The investigator was counseled on October 12, 2000.

3. All contractual employees should be given a copy of the "Code of Ethics for Child Welfare Professionals."

The Department agreed.

INVESTIGATIVE REFERRAL

Because of the possible criminal activity by a state employee, the case was referred to the Illinois State Police, Internal Investigations Division.

General Investigation 31

ALLEGATION A complaint alleged that a private agency mistreated the children in its care and covered up the abuse, misappropriated funds, improperly handled medications, followed discriminatory hiring practices and failed to conduct background checks on volunteers.

INVESTIGATION The OIG found that most of the allegations could not be substantiated. The agency had extensively documented instances regarding possible use of improper restraints and called the hotline or police when abuse was suspected. There was no evidence to support the claims of fund misappropriation, safety violations or discriminatory hiring practices. There was documentation showing three medication errors occurred over a 16 month span, however the agency's quality control system caught and recorded the errors.

Although there was no evidence to suggest the agency did not conduct background checks on its volunteers, the OIG has found this to be a widespread problem. Many agencies do not ensure all volunteers and subcontractors clear criminal and abuse/neglect background checks prior to beginning work.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES **The Department should notify private agencies that subcontractors and volunteers who have contact with wards must be cleared by criminal and abuse/neglect background checks.**

Administrative Rule 385, Background Checks, requires private agency staff to be subject to a background check. This includes any paid or unpaid individual who is allowed to be alone with children outside the visual or auditory supervision of facility staff.

General Investigation 32

ALLEGATION A book published by the Department violated trademark laws.

INVESTIGATION The Department published a book detailing post adoptive services for free distribution to the public through the juvenile court. The book's title and cover design were extremely similar to trademarked properties used by a popular series of children's books produced by a publishing company. The publishing company determined that the similarity constituted a "terrible infringement" on their licensed trademarks.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should cease publication and distribution of the book and actively attempt to retrieve as many circulated copies as possible.

The Department agreed. Notification was sent to all recipients of the publication that use of the book must be immediately discontinued. In addition, a letter was sent to the publishing company outlining steps that were taken to resolve the matter.

General Investigation 33

ALLEGATION	The four month-old daughter of two developmentally delayed adults was adopted outside the family, with the parents consent. The propriety of the adoption and the Department's involvement was questioned.
INVESTIGATION	The couple and their child had been living in a shelter because they felt it was the only place the three of them could live together. The father had been living at the paternal grandfather's home, but the mother was not welcome there. While at the shelter, the parents were the subject of three hotline reports, one of which was indicated for risk of harm; however, at no time was the child in the Department's custody. The couple was unable to locate alternative housing before they were required to leave the shelter. The father returned to his family home while the mother and their daughter went to live with the parents of one of the mother's former classmates. The couple decided they were unable to care for their child and told the Department caseworker assigned to them they wanted their daughter to be adopted by another family. The caseworker determined the couple was certain that adoption was appropriate for them and put them in contact with an adoption agency. The agency spoke with the couple's former school psychologist who stated they were competent to consent to an adoption. The couple appeared in court to surrender their parental rights and were deemed fit to do so by the presiding judge. The caseworker made counseling available to the couple and continued to provide services to them following the adoption.
OIG RECOMMENDATIONS / DEPARTMENT RESPONSES	**No recommendations made.**

General Investigation 34

ALLEGATION

A field office supervisor allowed a meeting involving several child welfare professionals and a foster mother to be tape recorded without receiving permission from all involved.

INVESTIGATION

Three individuals present at the meeting told the OIG that permission to tape the meeting was not received. All stated the tape recorder was plainly visible on the conference table they were seated around and at one point, the supervisor's secretary changed tapes. The supervisor told the OIG he was unaware his secretary taped the meeting and had not instructed her to do so. He said that while his secretary sometimes tapes meetings, permission is always asked of the participants beforehand. The supervisor stated that since the meeting in question he had told his secretary not to record meetings without consent.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The supervisor should be disciplined for permitting the illegal taping of a meeting for which he was responsible. He needs to recognize that his conduct, and in this case his disregard for the law, are observed by the people he supervises.

The supervisor was counseled regarding the use of tape recordings.

2. The legal parameters of taping meetings and interviews should be incorporated into DCFS Legal Services' training on confidentiality.

The Department agreed. The legal parameters of taping meetings and interviews will be incorporated into the legal portion of the Department's training on confidentiality.

General Investigation 35

ALLEGATIONS The Office of the Inspector General received a complaint alleging that the DCP Investigator assigned to investigate a man accused of sexually abusing his two children violated confidentiality by revealing the source of the hotline call and divulging information to the alleged perpetrator of the sexual abuse allegation.

INVESTIGATION The DCP investigator and the children's father frequented the same tavern. The tavern's owner told the OIG he knew both men but they were not friends with each other and that the DCP investigator had never said anything to him about the father. The investigator, who is black, told the OIG that the father is an avowed racist and has made it clear in the past he did not want to speak with anyone of another race. The investigator said the father was very uncooperative during the course of the investigation. He said the maternal grandmother did not like the father and would repeatedly call the investigator to make allegations, and if issues were not resolved to her satisfaction she would call the investigator's supervisor or other administrators to lodge complaints. The investigator denied he had ever violated confidentiality in any of his cases during the course of his long career with the Department.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES **Although there was no basis for determining that the investigator had breached confidentiality, the close social contact between the subject and the investigator created a potential appearance of conflict of interest. This case should be used as a training tool as an example of a situation that presents the appearance of a conflict of interest for an investigator so that the investigator should ask to be recused.**

The Department agreed. A redacted copy of the report has been forwarded to the Division of Training for implementation into the training curriculum.

General Investigation 36

ALLEGATION

An envelope sent from the Department's Legal division was returned for insufficient postage. Inside was a letter written to a man which threatened legal action against him if he did not make child support payments to the mother of his two children. The letter was written on Department letterhead and signed by someone purporting to be a Department attorney. The Department does not employ an attorney with the name signed to the letter.

INVESTIGATION

The OIG interviewed the mother of the children named in the letter. She denied any knowledge of its existence but stated that her sister worked for an employment agency that might have supplied temporary workers to the Department. Since the letter had been stamped using a postage meter, the OIG was able to determine the particular Department office it was sent from. A review of the employment agency's records showed the mother's sister had been assigned to that office for one week as a secretary. The OIG interviewed the sister who admitted writing the letter and creating the fictitious Department attorney. She denied that the children's mother was at all aware of her actions.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should conduct CANTS and LEADS checks on temporary employees before employment begins. Temporary employees should also be required to sign a statement that any abuse of state property or forms will subject them to immediate termination of their assignment and notification to the agency that placed them.

The Department agreed. All contractual employees are subject to background checks.

2.The employment agency in this case should be notified of the secretary's abuse of Department property during her assignment as a temporary employee.

The Department agreed. The personnel agency terminated the secretary's employment for stealing.

Inspector General Investigation into

Cook County Sexually Aggressive Children and Youth Program

OVERVIEW

This is the second report of the Inspector General's investigation into the implementation of the Sexually Aggressive[1] Children and Youth (SACY) program in Cook County. The first report[2] (June 30, 1999) found children as young as two years old designated as sexually aggressive.

Since 1994, the SACY program of DCFS has been charged with determining whether a child should be labeled sexually aggressive, assessing and tracking children and juveniles labeled as sexually aggressive, referring them for treatment, and monitoring their progress. Complaints about the Cook County SACY program from foster parents and officers of the court (combined with an OIG investigation of the murder of a 17 year old severely developmentally delayed ward, who was designated as SACY[3]), prompted the Inspector General to investigate the Cook County SACY practices for children and youth.

This second report presents the data and findings resulting from the Inspector General's investigation of the assessment and treatment of youth and young adults 8 to 20 years of age who are labeled as sexually aggressive. The Inspector General investigated a random sample of 46 juveniles from the total (over 1,300) list of juveniles in Cook County.[4]

FINDINGS

MAJOR AREAS OF FAILURE IN CURRENT SACY PRACTICE IN COOK COUNTY

1. Screening and Assessment Process

- The screening and assessment process failed to view the children in a developmental or contextual framework. This is a critical problem, since we know that many of our wards come into the system from deprived environments. Neglect, exposure to the drug culture and physical and sexual abuse can cause language delays, socially immature behavior and other behavior disturbances, including aggressive behavior, of which, aggressive sexual behavior is

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1 The program is officially called Sexually Aggressive Children and Youth. The Private Agency who administers the program has requested that the program be referred to as Sexually *Abusive* Children and Youth, to acknowledge that children in the program include those who do not exhibit aggression.

2 "An Investigation of Current Practices with Very Young Children Designated As Sexually Aggressive." Following the recommendations of that report: (1) All children eight years and under were removed from the SACY database, (2) A multi-disciplinary panel was formed and chaired by Dr. Boris Astrachan of the Department of Psychiatry, University of Illinois to review the SACY program in Cook County and to report their findings to the Director of the Illinois Department of Children and Family Services (DCFS). In addition, DCFS clinical staff reviewed the cases of 27 children in the original sample of children to be sure that they were removed from the SACY list and to insure that they were receiving a complete and appropriate service plan.

3 The girl had been inappropriately labeled, at the age of 12, as sexually aggressive. As a result, she was placed in an independent living program and denied educational entitlement because few programs were willing to accept her once she carried the label of sexually aggressive.

4 This report benefits from consultation with Dr. Barbara Bonner (University of Oklahoma) Dr. Judith Becker (University of Arizona) and Dr. William Friedrich (Mayo Clinic). Both Dr. Bonner and Dr. Friedrich generously agreed to review five complete case files as well as the overall findings in this report. In addition, the Inspector General consulted with Dr. Raymond Starr who is a leading expert in the field of developmental disabilities and sexual abuse.

a component. Developmentally, deprivation causes decreased impulse control and problem solving abilities.

- In most cases, reported facts allegedly demonstrating sexually aggressive behavior were not corroborated, verified or investigated other than through phone contact with the caseworker. In some cases, a child was placed on the SACY database based on incorrect information that was recognized by all parties involved, including the SACY program.
- There is a failure to differentiate between sexually abusive behavior (occurs without consent, without equality, or as a result of coercion) and sexually reactive behavior (children who display sexually inappropriate behavior in response to sexual abuse or exposure to explicit sexual stimuli.) Forty-six percent of the children in the Inspector General's sample were victims of sexual abuse
- The Cook County SACY program fails to differentiate between children who have an isolated incident of inappropriate sexual behavior from children and youth that are severely sexually aggressive. This creates an unacceptable false positive[5] rate for children and youth that are listed on the SACY database.
- There is a general failure to address the functional age of the child. The study found that 31 (67%) of the children reviewed in the random sample had serious developmental delays. Nine (22.5%) children in the sample had an IQ of 60 or below. A developmental approach limited to what is "usual and expected" for a given age is inappropriate since a majority of our wards are outside of the 'norm' with regard to developmental milestones. Similarly, limited cognitive abilities can seriously affect what is "usual and expected" behavior, especially when determining whether a child responded to appropriate redirection. Therefore it must be defined carefully for different populations.
- The case files contain information that may be myth, truth or contradiction. When inaccuracies are entered into the case file, the inaccuracies take on a life of their own with little resemblance to fact.
- The SACY program fails to address the fact that sexual behaviors may be a manifestation of the child's lack of socialization, which is best addressed through strategies that increase opportunities for development of pro-social skills. In some cases, the SACY program has ignored therapist's recommendation regarding lack of socialization related to sexual behavior.

2. Appropriate Services and Treatment

- In current practice, there is a lack of thorough assessment. This is critical for understanding the child and the source of his/her behavior. Without a good assessment, the service needs of the child cannot be met.
- In the 46 cases reviewed in this random sample, protective plans are often the only intervention that the child/ren actually receive. Protective plans are drawn up quickly, are not designed to address the child's specific needs, and, although they remain with the child throughout the years, are infrequently revisited.

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5 A false positive refers to; "Inaccurate estimates based on invalid tests [that] may harm clients." Gambrill, E. *Social Work Practice* Eileen Gambrill, Oxford University Press, New York, 434, 1997.

- The program fails to provide services to children who have multiple needs. There is documentation that 46% of the children were victims of sexual abuse, yet there is no indication that these children received 'victim' treatment.
- There is practically no treatment conducted at the home, no treatment aimed at fortifying pro-social skills and little evidence of foster parent involvement in treatment -- though research suggests that these are the most effective treatment modes.

3. Monitoring

- There was a general failure to monitor services in all areas of the child's life: treatment, education, compliance with protective plans, SACY status, living arrangements and other services needed.
- The investigation revealed no evidence of quality assurance or program fidelity or effectiveness assessment.
- Supervision needs of highly aggressive youth and young adults were inadequate. Several youth whose behavior legitimately warranted a sexually aggressive label were subsequently placed in independent living programs where they received minimal supervision, thereby threatening community safety. One of the wards resided in a YMCA with a daycare center. This ward had been charged with Aggravated Criminal Sexual Assault for the repeated oral and anal assault of both his 10-year-old brother and his brother's friend.
- Court intervention was underused. Of 46 youths in the random sample, 8 youths were referred to Juvenile Court for delinquent offenses and only 4 were referred for the sexual behavior that caused them to be placed on the SACY database. Of the four who were charged with sex offenses, two of the petitions were dismissed in court.

POSSIBLE DISCRIMINATORY EFFECT OF COOK COUNTY SACY PROGRAM

The Inspector General's investigation strongly suggests that the current administration of the SACY Program may run afoul of federal and state anti-discrimination laws in four significant respects. First, the program results in adverse consequences to victims of abuse and neglect (state wards) for behavior that does not subject non-wards to the same consequences. Second, these adverse consequences may amount to a deprivation of liberty without due process. This is especially true given the almost complete failure to investigate the veracity of allegations before imposing consequences that implicate a child's civil rights. Third, the high percentage of developmentally challenged wards suggests that the program, as currently administered, targets wards because of their disabilities. The current matrix is not normed for children with developmental disabilities, learning delays or other cognitive limitations, especially those from deprived backgrounds. These children are more likely to be targeted because they are more likely to engage in age inappropriate behavior and are less likely to respond immediately to redirection. Children should not be deprived of education and pro-social opportunities simply because their learning disabilities or developmental delays make it harder for them to learn appropriate behavior. Restrictions on educational opportunities may also violate federal law. Fourth, as Boat and Everson (1990) demonstrated, inner-city youth may demonstrate knowledge or behaviors of a sexual nature that seem age-inappropriate, if using an assessment device that has not been normed for work with the specific population. The Cook County SACY program labels some children as SACY for behavior that is merely offensive or inappropriate without being aggressive. To the extent that children are labeled as SACY for non-aggressive behavior, it may also reflect discrimination based on class or race.

DEMOGRAPHICS OF THE SAMPLE

This investigation reviewed a random sample of 46 cases of children and young adults who are between the ages of 8 and 20 and have been designated as SACY as of July 1999. The DCFS or POS agency case files were reviewed as well as SACY program files. In some cases where education materials were not current in the file, supplementary Individual Education Plan's (IEP) were requested from schools. OIG investigators also reviewed materials from the Chicago Public Schools Information Office at Juvenile Court for education information.

Sex, Age, Race and Placement History

The sample consisted of 32 (69.6%) males and 14 (30.4%) females. At the time the sample was taken, the average age was 13.93; the youngest child was 8 and the oldest youth was 20 years old.

In this sample, 40 (87%) of the children were African-American, two (4.3%) were Caucasian, two (4.3%) were Hispanic, one (2.2%) was Puerto Rican-American, one (2.2%) was Puerto Rican/African-American.[6] The children's average number of placements was 6.85; the least number of placements that a child had been in was one and the highest number of placements was 20. [7] Twelve (26.1%) of the children in the sample were separated from a sibling as a direct result of their SACY designation. Six (13%) of the young adults in the sample either have been or are currently in an independent living program. The average number of changes in caseworkers for children in the sample was 9.5, with a minimum of 2 and a maximum of 20 workers.

History of Abuse

In the Inspector General's sample, 21 (45.7%) of the children had been sexually abused. In most cases, a relative, foster parent or other adult sexually abused the children. Twenty-seven (58.6%) of the children were exposed to adult sexual behavior or materials.[8] Twenty-four (52.2%) of the children were physically abused. Ten (21.7%) of the children were born drug exposed[9], and 35 (76.1%) were environmentally exposed to drugs.[10] Thirty-two (69.6%) of the children displayed aggressive behaviors that were not sexual in nature.

Children with Special Educational Needs

Thirty-one (67.4%) of the children in our sample are *either* developmentally delayed or learning delayed. The average IQ of the children in this sample is 73.9. IQ results were unavailable for six cases. For the 40 cases in which IQ was available, the lowest IQ was 44 and the highest was 99. Nine (22.5%) of the children had an IQ of 60 or lower.

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6 Statistics for all Children and Youth on SACY database in Cook County as of June 2000, N=938: Gender- 71% Male, 29% Female, Race- 82% African-American, 9% Caucasian, 6% Hispanic, Ages- (9-12) 37.2%, (13-17) 47.6%, and (18+) 15.1%.

7 All placements were taken from CYCIS for consistency. All placements over five days were counted as a change, including hospitalizations. Duplicate placements were counted separately if a significant amount of time passed between placements.

8 This generally refers to exposure to pornographic materials or witnessing adult sexual activity, not including masturbation. This was counted as "yes" in cases where a child had been sexually abused by an adult age 18 or older.

9 This refers to instances in the case file where it was specifically stated that the child was born drug exposed.

10 Environmental drug exposure refers to an environment where at least one adult in the home was a substance abuser, the child had at least one sibling who was born drug exposed, drugs were sold out of the home or the minor personally sold or abused drugs.

Thirty-four (73.9%) of the children are currently or have been in a specialized school program.[11] Twenty-eight (60.8%) of the children in the sample had been classified by the Chicago Public Schools (CPS) as having a disability which would affect school performance. The remainder of the children were in programs in schools outside of the CPS system. Of the 28 children evaluated by the Chicago Public Schools, 14 (50%%) were classified as having an emotional behavior disorder (EBD), 7 (25%) were classified as having a learning disability (LD), 5 (17.8%) are educable mentally handicapped (EMH), one (3.5%) is trainable mentally handicapped (TMH) and one (3.5%) is 504[12]. Some of the children in the group of 28 had multiple diagnoses. The following table illustrates the primary and secondary disability classifications for the 28 children in the random sample who have had a diagnosed learning/developmental disability by the CPS.

Frequency of classifications of children in this sample who are or were in the Chicago Public Schools in a specialized school program: N=28

	As a primary classification	As a secondary classification	As an only classification	Explanation of secondary classifications
Emotional Behavior Disorder (EBD)	14	1	8	Of the remaining 6 children (who had a secondary classification); 3 had a secondary classification of LD, and 3 were diagnosed with a speech language deficit (SPL).
Learning Disabled (LD)	7	3	5	Of the 2 remaining children, 1 had a combined secondary classification of VI2/SPL[13] and 1 had a combined classification of SPL/EBD.
Educable Mentally Handicapped (EMH)	5	0	2	Of the 3 children who had a secondary classification; 1 had a secondary of EBD, 1 had a secondary of SPL and 1 had a combined secondary of EBD/SPL.[14]
Trainable Mentally Handicapped (TMH)	1	0	0	The one child with a classification of TMH had a secondary classification of SPL.
Speech Language Deficit (SPL)	0	5	0	No children had this as a primary classification. Five children had this as a secondary classification.
EBD/SPL	0	2	0	No children had this as a primary classification, but two had this as a secondary classification.
Other	1	0		One child had a primary classification of 504 (see above text).

11 If a child was in a specialized school program when they were last in school (even if they have since aged out of the school system) they were counted as participating in a specialized program.

12 A 504 disability refers to "persons who have, have a record of having, or are regarded as having physical or mental impairments which substantially limit one or more major life activities." Chicago Public Schools, "IEP Workbook," 1998, Board of Education.

13 Visual and speech deficiencies.

14 This child had been given a primary diagnosis of EBD with a secondary of EMH/SPL. This diagnosis was likely given due to the lack of an EMH classroom in the school.

SACY Case History

The average age of the children reviewed in this sample at the time of the first reported incident was 10.78 years. The youngest that a child was designated as "SACY" was four and the oldest age at which a designation occurred was eighteen. Twelve (26%) of the children were under the age of eight when their first incident occurred. The following table illustrates the age of the child at the time of the first reported incident that led to the SACY designation.

Age of the child at the time of the first SACY related incident

	4 yrs.	5 yrs.	6 yrs.	7 yrs.	8 yrs.	9 yrs.	10 yrs.	11 yrs.	12 yrs.	13 yrs.	14 yrs.	15 yrs.	16 yrs.	17 yrs.	18 yrs.
# Of child-ren	1	1	2	8	3	5	1	6	2	6	3	2	4	0	2
% of the sample	2.2	2.2	4.3	17.3	6.5	10.9	2.2	13	4.3	13	6.5	4.3	8.7	0	4.3

The average number of alleged incidents of sexual behavior that occurred prior to the child receiving a SACY designation was 1.54 with a minimum of 0 and a maximum of 5.[15] The average number of reported incidents after the SACY designation was .85 with a minimum of 0 and a maximum of 15 incidents. Twenty-nine (63%) of the children in the sample were designated as SACY after a single incident. The following table illustrates the frequency of the number of incidents that were reported after a SACY designation.

Frequency of the number of incidents *after* a SACY designation

# Of incidents	**0**	**1**	**2**	**3**	**4**	**5**	**6-14**	**15**
Instances of recurrent behavior	37	2	1	2	1	2	0	1
% Of cases	80.4%	4.3%	2.1%	4.3%	2.1%	4.3%	0%	2.1%

The average number of years that a child has been designated as SACY, as of July 1999, is 2.54 with a minimum of zero (less than one year) and a maximum of six years.

Twenty (43.5%) of the referrals to the SACY program were made according to the SACY standards by way of an Unusual Incident Report (UIR). Sixteen (34.8%) of the cases were referred by a phone call directly to the SACY program and seven (15.2%) cases were referred by both UIR and a direct phone call. Two (4.3%) of the cases had no information in the SACY file as to how the referral came in and in one (2.2%) case the referral was made by "other" (such as a police report).

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15 For statistical purposes, the number of incidents before designation for each child in the sample was recorded as 1 or more. This is regardless of any information that might indicate that the reported allegation of sexually inappropriate behavior was incorrect. Any number higher than five was recorded as five. In two cases, the number of incidents was recorded as zero. In the first case, SACY staffed the case (#7) and determined the child was non-SACY, yet entered her name on the database in error. In the second case, the child was wrongfully named as the abuser. This was recognized throughout the file as an error yet the child's name was not removed from the database.

Therapy

Information regarding any therapy that a child was engaged in was limited in both the case files and the SACY files. According to available information, 23 (50%) of the children in the random sample were receiving some therapy as of July 1999. This does not necessarily mean that they were engaged in SACY specific therapy, as required by the SACY standards. A review of the SACY files of this sample indicated that SACY had, in accordance with their own standards, monitored therapy in only 16 (34%) of 46 cases with a total of 33 quarterly therapy reports throughout the cases in the random sample. Many of the reports that were in the files were sparse and did not provide substantive information by which efficacy of treatment could be assessed. There was no case in which there were consistent quarterly therapy reports during the course of treatment. In 36 (78.3%) of the cases in the total sample, there were records indicating that at some time the child had been involved in therapy that had addressed issues that were not related to sexual behaviors. Often, a child had been previously involved in these types of therapy with no connection to the SACY program. Again, the limited therapy information found in the SACY files made it impossible to obtain an accurate measure of how many children were successfully referred for treatment via the SACY program. Forty-one (89.1%) of the children in the sample had a recognized mental health diagnosis. Eighteen children (39.1%) were listed as receiving medication. In eight (17.4%) cases a child was receiving other special services, such as speech therapy.

RECOMMENDATIONS

1. Rather than spending approximately $1.2 million over the next 18 months for the existing contract with the private agency, it would be more prudent for the Department to redirect these resources to the DCFS Best Practice Unit of the Clinical Division. The Department should not renew its contract with the private agency for tracking or intervention with wards or training and certifying SACY providers for FY2001, and transfer those responsibilities to the DCFS Clinical Division. The private agency does not have the requisite child development expertise and the Inspector General's investigation has revealed that the private agency has administered a program that may discriminate against children with developmental delays and may also be discriminatory against DCFS wards.

The Department agreed to modify its contract with the private agency and transfer responsibility for tracking and intervention to the Division of Clinical Services. This transition plan is currently being developed. The Department will also review the agency's role in training and certification of providers and make appropriate modifications in the agency's contract.

2. Redirect all Unusual Incident Reports (UIR), questions and concerns regarding a child's serious aggressive behavior to the DCFS Best Practice Unit of the Clinical Division and discontinue the SACY database for all children and youth.

A. This unit will develop a screening and assessment referral system to offer assistance to children and families. [16] Further, this unit will develop a triage approach that would immediately refer children with developmental delays or severe learning disabilities to appropriate experts in child development and specialized knowledge of developmental disabilities for assessment, and development/implementation of a service plan for the child and caregivers.

16 DCFS procedure PT 99.14 Subpart C, Appendix N, June 15, 1999 states, "Assessment tools for other children and youth may not be appropriate for youth with developmental disabilities. The child welfare worker should consult with staff of the Department's Clinical Division to determine assessment needs."

The Developmental Disabilities Coordinator should be designated to monitor follow-up for children who have developmental disabilities.

B. Reports of alleged sexually abusive behavior must be subject to a careful and *thorough* investigation. [17]

The Department is in the process of incorporating this into the DCFS SACY Liaison's job responsibilities. The SACY database is being reviewed for needed changes and utilization issues.

A. The Department has worked with the OIG's office in developing an initial program plan with a state university. The Developmental Disabilities Coordinator has been involved in the development of this program and will continue assisting, as needed. A contract for initial services has been developed.

B. The Department agreed and is in the process of redesigning the current screening system, which will ensure that information is thoroughly reviewed. The DCFS SACY Liaisons under the auspices of the Clinical Division will be responsible for future screenings. Implementations of the program will be contingent upon review and approval by DCFS of the DDHD proposal.

3. Children with average cognitive abilities will be referred to a diagnostic center for assessment using the program guidelines recommended in "Treatment of Children with Sexually Problematic and Aggressive Behavior." (Horton, 1999)

The Department agreed and will implement utilizing a comprehensive diagnostic for assessment and not solely based on the alleged sexual incident. This approach will enable children and youth to receive appropriate treatment based on their overall needs as opposed to "stand alone" treatment for the sexually abusive behavior.

4. The Best Practice Unit must include pediatricians, child psychologists and human development professionals with expertise in child development and aggression behavior management in the training of any DCFS designated screeners and assessors. The training must cover child and adolescent development including sexual development and developmental issues in the foster care population.

The Department agreed and this will be initiated via the Department's Behavioral Health Initiative, which is overseen by the Clinical Division. The Department also agreed that child and adolescent developmental issues are key to all aspects of training for individuals working with children and youth.

5. The Department should fund multi-systemic therapy services for wards in foster care who have multiple delinquent petitions either pending or adjudicated. The service model should be true to the integrity of the evidence-based research. In addition to foster care,

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17 In his communications with the Inspector General, Dr. William Friedrich identified nine reference points for assessing sexually aggressive behavior in children as utilized in Toronto, Ontario. The points include: non-mutuality, harm/discomfort caused to others, complaints by others, differential power/not peers, persistence despite limit setting by others, coercion/bribery, force/threat of force, premeditated/planning/forethought and extensive adult-type sexual behavior.

these services should be available to biological families when reunification could be viable with this service.

The Department agreed and is working with the Cook County Juvenile Court, The University of Illinois and the Community Mental Health Council to pilot a multi-systemic therapy program to serve children with multiple delinquent petitions. This program will be put in place in the next 12 months. The program will have an evaluation component and, if it results in positive outcomes for children, will be replicated.

6. The Department should conduct an objective analysis for youth with major aggressive behaviors and/or undersocialized behaviors. This analysis should include a description and history of the presenting problem behaviors (including cycles, frequency, rate, duration and intensity), as well as identifying conditions that precede the behaviors (specific times and events), consequences (reactions/effects that might maintain behavior) an analysis of the meaning (functions served by the behaviors) and review of medications in relationship to behaviors. Undersocialized youth should be assessed for functional life skills. A plan should be implemented for all youth who exhibit aggressive behaviors to protect the youth as well as the community.

The Department has developed a behavioral assessment protocol that focuses on the identification and analysis of conditions supporting the maintenance of major aggressive and/or undersocialized behaviors. Implementation will occur in conjunction with the Department's Behavioral Health Initiative.

7. The OIG learned that the Department had recently contracted with a private agency to perform a longitudinal five-year study of SACY wards. The Department should ensure that the population included in the longitudinal study is exclusive of the children with cognitive limitations.

The Department and the OIG met with the private agency to work out a process where developmentally disabled children will be first screened through DDHD before inclusion in the study.

8. Whenever possible, home and family-based therapeutic services that include appropriate developmental opportunities for children with behavioral problems, as well as developmental pathways such as leisure and recreational activities must be used. Behavioral home-based family intervention is effective in creating more positive outcomes for children in the family and caretakers. [19]

The Department agreed. The Department is working with HELP Incorporated to establish a training program for foster parents, which will focus on home-based clinical interventions that parents can use with sexually abusive youth. This program does include training on the therapeutic use of leisure and recreational activities.

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19 "The provision of in-home services was a positive factor and should be continued. However, it was typically lacking. Provision of consultation to the foster parents probably would have been the most effective intervention." General observations of cases reviewed, by Dr. Bonner and Dr. Friedrich. Dr. Friedrich further suggested, "The behavior of all preteens is so much a function of the child's context, and without systems involvement, true changes are not likely." (Letter to the Inspector General, 6/5/00.)

9. After an initial screening by the Best Practice Unit, they will assist caseworkers to create a temporary protective plan during the child's thorough assessment. The temporary protective plan will remain in place while a complete assessment/investigation is done. Protective plans should be used as a temporary measure to ensure safety of all involved. However, if an extended protective plan is needed, it should include as much opportunity for socialization as possible for the child who is being assessed. [19]

- The Department agreed. The Clinical Division will oversee the Development of a new format for protective plans which are individualized to the child and youth's situations and needs, including the interim plan developed prior to assessment and screening.

- 10. When inaccuracies or errors about alleged behaviors are discovered within a case file, written documentation and acknowledgement of this error must be inserted into the file and presented to court, if appropriate. [20]

- The Department agreed and the DCFS SACY Liaisons will provide said documentation.

11. DCFS has inadequate information regarding the behaviors that require medications. The complete records of a child must be reviewed to be able to evaluate a child's medical needs. [21]

- The Department agreed and in regard to SACY, this will be a part of the screening process.

- 12. Implement expansion of the Child and Youth Centered Information System (CYCIS)/SACWIS tracking system to include a treatment history screen. Psychological treatment and counseling are among the most vital services the Department provides to wards, however current practices make it difficult for workers to construct an accurate perspective of a child's treatment history. Integrating pertinent information into the system would allow workers to develop an awareness of past treatment and monitor further care.

The Department agreed and this is one of the areas that is already being addressed by the SACWIS project.

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19 Forbidding contact sports for young males is an example of misplaced concern. Other examples such as requiring a signed commitment from the Park District that the child will never be left alone with another child prevents normal activities available to minority youth from impoverished communities youths.
20 Even though two incidents of sexually inappropriate behavior have been determined to be misinformation, one child (#11) remains on the SACY database, and all related information remains in his case file.
21 In their review of five cases, Dr. Bonner and Dr. Friedrich questioned the high volume of the medications that the children were receiving.

ADDITIONAL TOPICAL RECOMMENDATIONS

Periodically, for reasons of safety or follow-up on a previous recommendation, the OIG requests the immediate attention of the Director's Office.

MENTAL HEALTH TASK FORCE / PARENTING ASSESSMENT TEAM

The Parenting Assessment Team (PAT) program, established in 1994, was designed to provide the Department and the courts with comprehensive, methodologically sound, non-adversarial assessments of parenting capabilities and risk factors. The OIG met with members of the three Parenting Assessment Teams as well as a representative from the Department's Clinical Division to discuss critical issues. The meeting produced the following recommendations:

OIG Recommendation: **PAT reports involving Division of Child Protection (DCP) referrals and/or Intact Family cases should include a safety plan as part of the PAT recommendations.**

Department Response: The Department agreed. Whenever an assessment of DCP and/or intact family cases indicates safety issues, specific recommendations addressing safety planning will be made, including the development of a safety plan. If appropriate to the presenting problem and the case planning needs of the family, a recommendation for an order of protection and/or the use of the mental health treatment preference declaration will be effected.

OIG Recommendation: **PAT coordinators/social workers should present a copy of the PAT report at Administrative Case Reviews (ACR). ACR reviewers would benefit from an orientation by the PAT in their region.**

Department Response: The Department agreed. Copies of the PAT report, including recommendations for parental and/or client services are now routinely presented at Administrative Case Reviews. A DCFS policy change requires that a copy of the PAT report be forwarded to the regional Administrative Case Reviewer, and that implementation of PAT recommendations be monitored. The DCFS Statewide Coordinator for PAT programs is provided with a monthly ACR report detailing issues related to implementation of PAT recommendations. Regional ACR reviewers are scheduled to receive an orientation to the PAT program by the Office of the Statewide Coordinator of PAT services and representatives from the PAT programs.

OIG Recommendation: **Court officials and personnel and child welfare professional should be made aware of the fact that there are now three Parenting Assessment Teams. They should also be informed as to how to make referrals to the Team in their respective regions.**

Department Response: The Department agreed. Notification of the operation of the three PAT programs has occurred. The March 16, 2000 memo that was distributed to DCFS and Purchase Of Service (POS) staff has been distributed to DCFS legal offices and POS agencies. DCFS regional psychology consultants have met with PAT staff to receive an orientation and are now actively assisting regional staff to make referrals for PAT assessments.

INDEPENDENT LIVING PROGRAM

The OIG reviewed several reports from private agencies and the Department's Division of Clinical Services regarding the safety of wards in a private agency's independent living program.

The OIG had previously recommended to the Department that this program be closed following the investigation into the murder of a 17 year-old female ward who was a participant in the agency's independent living program at the time of her death. In reviewing these reports, the OIG found that the needs of the wards in the program were not being met and information that was integral towards ensuring the wards were receiving the proper services was not being forwarded to the Department Administrator identified as the lead person assigned to work with this population.

OIG Recommendation: The OIG stands by the original recommendation to close the agency's independent living program. In addition, the Department has an obligation to immediately address the needs of all wards in the program. Many are approaching 21 years of age. The Department needs to act quickly to achieve appropriate living arrangements and services to meet their needs. This may require collaboration with other resources including adult living programs, probation departments and public aid.

Department Response: The Department agreed. The private agency has been notified that their contract will be terminated. The final target date for termination is December 30, 2000. Admissions to this program for youths with developmental disabilities and Sexually Aggressive Children and Youth (SACY) issues were closed during the second quarter of Fiscal Year 2000. Admissions for all other youths were closed during the fourth quarter of Fiscal Year 2000. The Division of Operations, in conjunction with the Division of Clinical Services, are cooperating on transitional planning for any remaining youths in the program.

OIG Recommendation: The Department should ensure that the Children and Youth-Centered Information System (CYCIS), and in the future the Statewide Adult and Child Welfare Information System (SACWIS), reflect the actual addresses of all wards in independent living arrangements.

Department Response: The current system (MARS/CYCIS) does not accommodate this recommendation. In order to obtain payment, the youths in independent living programs must be registered at the independent living program provider and the address of the provider must be shown on the system. This recommendation has been referred to SACWIS/Best Practice for inclusion in the new system.

TEEN PARENT SERVICE NETWORK

Two recent OIG investigations have suggested the need for an integrated child welfare approach to independent living and teen parenting that emphasizes education and job training. At the OIG's request, a private agency accumulated data regarding the number of pregnant and parenting teens enrolled in school. The agency found that of the pregnant and parenting teens not in school, 84% stated "personal choice" as their reason for not attending.

OIG Recommendation: In order to reduce the number of teen parents who "choose" not to attend school, independent living plans for this population should be designed to integrate education as a required element of their services. This would include vocational and educational testing and presentation of school options, scholarship set-asides and college consultation and accessible health services and day-care. Housing and other benefits would be tied to cooperation with program components in order to help ensure compliance. All data collected from the program should be saved for continuing research.

Department Response: The Department, the private agency, the OIG and the Teen Parent consultant have had several meetings to discuss education issues. Recent data has been provided detailing information regarding pregnant and parenting youth who are not in school, including their grade levels, reading and math levels, credit summaries, and last school attended. Additional information will be provided by the private agency regarding children attending school. Several initiatives and strategies were discussed at the last meeting on December 5, 2000 and are in the process of being implemented.

HEALTHWORKS

Through discussion with a private agency program manager, the OIG learned of policy guidelines followed by a health care program for older female wards that did not provide services as efficiently as possible. The manager stated that PAP smears and tests for sexually transmitted diseases (STD) were not routinely performed, though most of the girls were sexually active. She also noted that if a girl decided to begin using Depo-Provera as a method of birth control, she was required to take the prescription to a pharmacy and then return for a follow-up appointment to have the treatment administered. The manager believed this was done for the financial benefit of the clinic at the expense of making the process more complicated for the ward. It also became apparent that too few clinics are part of the health care provider network, resulting a lack of coverage in some areas of the state.

In response to these concerns, the OIG made the following recommendations:

OIG Recommendation: Qualified health care providers around the state experienced in serving a young female population should be added to the network.

Department Response: Primary care providers must meet certain criteria to qualify for participation in the network. The Department agreed to work with the appropriate Lead Agencies to determine whether the agencies specifically cited by the OIG meet those criteria.

OIG Recommendation: The requirements for annual physical examinations should be adapted to require necessary PAP smears and STD testing for female teens who are sexually active.

Department Response: The Department follows health care requirements per the Federal Medical Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. The Department of Public Aid's provider manual for the EPSDT program recommends PAP smears and STD testing for adolescent girls who are sexually active.

OIG Recommendation: The Department should investigate and eliminate financial barriers to providing Depo-Provera.

Department Response: As the single State Medicaid Agency, the Department of Public Aid is responsible for setting funding and policy for Medicaid reimbursed prescriptions. The Department agrees to work with the Department of Public Aid to determine whether it is possible to change current DPA reimbursement standards involving Depo-Provera.

HEALTH FORUMS

The OIG's investigation into the death of a seven year-old girl whose family was receiving intact family services from a private agency found that the girl's limited contact with teachers, child

welfare professionals or health care providers put her at increased risk by reducing the likelihood that a concerned adult would recognize her health conditions, including an undiagnosed breathing problem.

In response, the private agency that provided services to the family, in conjunction with the OIG, has initiated quarterly Health Forums on children with asthma for intact family workers. In addition, the private agency has begun to use an asthma screening assessment tool with their intact family cases in order to identify children with asthma or possible asthma. A clinic has agreed to provide medical care and asthma education for children identified by the program.

EMPLOYEE LICENSURE

As part of the effort to improve the level of services being provided to wards, the Department has moved to implement Rule 412 requiring all workers to be licensed. The OIG learned that under the provisions of this Rule, foster home licensing personnel would be excluded from fulfilling this requirement. Foster home licensing workers serve a critical function in determining the appropriateness of the homes where the children DCFS is charged with protecting are to be placed. These workers must always evaluate the safety of children in the home while performing their duties, and it is with children's welfare in mind that staff engage adults and homes in the licensing process. In addition, these workers are in a unique position of power with respect to the foster homes they license. As such, they should be held to at least as high a standard of care as other workers.

OIG Recommendation: Foster home licensing workers should be required to be licensed.

Department Response: The Department agreed. Foster home licensing workers will also be required to be licensed..

COOPERATION WITH OIG INVESTIGATIONS

The OIG was made aware of three separate incidents in which upper-level management within the Department instructed staff to be less than fully cooperative with OIG investigators. The OIG did not open investigations into these incidents because the reports themselves were sufficiently reliable and there was concern that initiating inquires could result in retaliation by Administrators against the employees who made the reports. All Department employees are required to cooperate with the OIG. The potential danger that could result from systematic refusal to comply with OIG efforts cannot be understated.

OIG Recommendation: The Department should distribute a memo to all upper-level management and staff reinforcing the importance of cooperating with OIG investigations.

Department Response: The Department agreed. An information transmittal was sent to all staff on June 12, 2000 to clarify and reinforce existing departmental policy with respect to cooperating with the OIG.

OIG Recommendation: The Director should meet individually with each of the upper-level managers involved in the above allegations to ensure that they understand their responsibilities in terms of encouraging staff to cooperate and communicate with the OIG and to ensure that they understand that any actions similar to those described above will not be tolerated.

Department Response: The Department agreed. Appropriate action was taken by the Director's Office.

MISUSE OF DEPARTMENT RESOURCES

An employee verification letter that had been submitted as part of an apartment application was returned to the Department. The letter stated that the applicant, who had worked temporarily for the Department for approximately one year, was still employed by the Department and had been for four years. The letter had been notarized by a Department secretary who is also a certified notary public. The secretary told the OIG she was asked to type and notarize the letter by a Department employee who had supervised the applicant. The employee was the subject of several OIG investigations before resigning from the Department.

OIG Recommendation: The secretary should be counseled on using more caution about doing things for others that may not seem work oriented. She should not be authorized to notarize any documents for the department and a memo to that effect should be sent to her supervisor.

Department Response: The Department agreed. The counseling session was held on November 19, 1999. The secretary was also directed not to notarize any Department documents.

CASE TRACKING

A woman called to inform the OIG that she was receiving calls intended for the Department's Case Tracking Unit on her cellular phone. The OIG found that a previous number for the Case Tracking Unit was the same as the woman's number but with a different area code. The Unit's most recent former number was a live line but did not inform callers of the new number, prompting them to attempt to call the old number and dial the woman's cell phone in error.

OIG Recommendation: For the benefit of associated agencies, law enforcement and health care professionals who are trying to reach the case tracking unit, the Department should record a message on the old phone line informing callers of the new number. The Department should also take steps to ensure that the new number is widely disseminated.

Department Response: In March 2000, the case tracking number was disconnected and a referral put on it to a new line. All calls are being routed to the new number.

COOPERATION WITH LAW ENFORCEMENT AGENCIES

The OIG was informed that an Administrative Law Judge had received a voice-mail message from an unknown caller who threatened to kill her. The OIG compiled and transmitted the relevant information to the Illinois State Police for investigation.

A former private agency employee threatened a Regional Counsel for the Department. The OIG compiled and transmitted the information to the Illinois State Police for investigation.

A review of the day care payments processed by a temporary employee who had been working in the Office of Child Development for six years found that an unusual number of duplicate payments, totaling $26,649, had been made to a single licensed day care provider. The OIG compiled the information and forwarded it to the Illinois State Police Task Force on Financial Crimes for investigation. The Department fired the temporary employee and informed the staffing agency she worked for of the decision.

The OIG received several complaints alleging mismanagement and misappropriation of funds by a private agency and the agency's handling of cases and foster home licensing problems. The OIG concluded that the Department acted irresponsibly by transferring problematic cases from troubled agencies to the agency in question, which had only recently begun operation. The OIG compiled relevant information regarding misappropriation of funds and forwarded it to the Illinois State Police Task Force on Financial Crimes for investigation.

The OIG received a Request for Investigation alleging that a private agency was operating outside the parameters established for not-for-profit organizations or child care institutions. The OIG found that the agency, which was in serious organizational distress, was not adhering to acceptable standards of financial practice. The agency's Executive Director owned two buildings which he rented to the agency for use as residential group homes at prices that an independent assessor determined to be substantially above fair market value. The OIG forwarded the information to the Illinois State Police Task Force on Financial Crimes for investigation.

The OIG received a request for assistance from police investigating an allegation that a Department child welfare specialist had molested his daughter's friends while they were in his home. The police were seeking information regarding a previous unfounded report against the Department employee. The OIG obtained pertinent information from the employee's personnel file and related to the detective. The child welfare specialist's employment was subsequently terminated by the Department on April 6, 2000.

A DCFS Licensing investigator was arrested and charged with contributing to the delinquency of a minor and harboring a runaway after it was discovered that a 16 year-old girl had been living in her home. The girl was involved in sexual relations and drug use with the investigator's 34 year-old brother who also lived in the home. The investigator told the police she was aware of the behavior but that it was confined to her brother's room. The OIG obtained all police information related to the investigation. The licensing investigator was discharged for cause on November 11, 2000.

best interest with regard to living arrangements, service and treatment. The OIG obtained copies of the boy's records and prepared them for review.

The OIG was contacted by the U.S. Customs Service regarding their suspicion that a 20 year-old Department ward in an independent living program was "renting" her children as cover for drug runners traveling between the U.S. and Central America. The Customs Service suspected the couriers were smuggling cocaine inside baby formula containers. The Customs Service required the OIG's assistance to locate the mother. The OIG verified the mother's address and assisted in arranging an interview.

The OIG was contacted by a Police Commander regarding a teenage girl who accused her step-father of molesting her. The step-father had previously been convicted of molesting her in 1995. The step-father was living with the daughter and her mother who had stated to police that she did not believe the charges. The commander was concerned about the mother's willingness to protect her daughter in this environment. The OIG forwarded the information regarding the step-father's previous conviction to the Division of Child Protection (DCP) investigator assigned to the case. The girl was subsequently removed from the home.

CHILD DEATHS

The Office of the Inspector General (OIG) tracks, reviews and investigates deaths of children whose families have been involved with DCFS at the time of their death or within one year of their death. During Fiscal Year 2000 (FY 00), the OIG received reports of 97 deaths of children meeting this criteria.[22] A summary of each of these deaths follows this report.

Using the child death database created by the OIG in FY 99, the OIG categorized the FY 00 deaths reported to our office by a variety of criteria including, cause, manner, ages, perpetrator, substance exposure at birth, substance abuse in the family, and county of death.

Homicide

There were a total of 20 deaths ruled homicide. The specific causes are detailed below.

* 8 children died from inflicted head trauma
* 5 children were killed by multiple trauma injuries
* 3 children were killed by gun shot wounds
* 1 child was killed by a stab wound to the chest
* 1 child was killed by strangulation
* 1 child was killed by drowning
* 1 child died from cocaine intoxication

Perpetrators

* 4 mothers killed children
* 4 boyfriends of mothers killed children
* 2 fathers killed children
* 1 step-father killed a child
* 1 foster father killed a child
* 1 foster sister killed a child
* 1 maternal grandmother killed a child
* 1 rival gang member killed a child
* 1 unrelated teenager killed a child
* 1 unrelated adult killed a child
* 3 perpetrators were unknown

Ages of Children

* 5 children were under six months
* 2 children were six months to one year
* 4 children were ages two to four years
* 1 child was age five to seven years
* 2 children were age eight to ten years
* 3 children were age eleven to thirteen years
* 1 child was seventeen years
* 2 children were over eighteen years

Male/Female Breakdown of Perpetrators

* 7 perpetrators were female
* 10 perpetrators were male
* 3 perpetrators were unknown

Ages of Perpetrators

* Female perpetrators were from 13 to 43 years
* Male perpetrators were from 16 to 36

County

* 1 death occurred in Champaign County
* 16 deaths occurred in Cook County
* 1 death occurred in Jackson County
* 1 death occurred in St. Clair County
* 1 death occurred out-of-state

Substance Exposure at Birth

* 2 children were substance exposed at birth
  - 1 exposed to PCP
  - 1 exposed to cocaine

22 Last fiscal year, the OIG received 82 reports from the State Central Register meeting this criteria.

Substance Abuse in the Family of Origin
* 7 families had evidence of substance abuse
    1 family had PCP users
    4 families had cocaine users
    1 family had heroin users
    1 family used marijuana

Suicide

1 death was ruled a suicide
* 1 16 year-old boy committed suicide. He shot himself in the head with a gun.
* The boy had a history of mental illness. There was no evidence of drug abuse.
* The death occurred in Sangamon County.

Undetermined

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

There were a total of 16 deaths found to be undetermined in manner. The specific causes are listed below.
* 13 deaths had undetermined causes
* 1 death was caused by an acute asphyxial event
* 1 death was caused by blunt force trauma
* 1 death was caused by dehydration, bronchopneumonia and child neglect

Ages of Children
* 11 children were under six months
* 4 children were six months to one year
* 1 child was three years
* No children were over the age of three

County
* 10 deaths occurred in Cook County
* 1 death occurred in Effingham County
* 1 death occurred in Jefferson County
* 1 death occurred in Kankakee County
* 1 death occurred in Sangamon County
* 1 death occurred in Vermilion County
* 1 death occurred in Winnebago County

Substance Exposure at Birth
* 6 children were born substance-exposed
    3 exposed to cocaine
    2 exposed to opiates (one codeine)
    1 exposed to alcohol and cocaine

Substance Abuse in the Family of Origin
* 9 families had evidence of substance abuse
    4 families had cocaine users
    3 families had alcohol users
    1 family had opiate users
    1 family with polysubstance abuse

Stillbirth

There were a total of 5 stillbirth deaths. The specific causes are listed below.
* 2 stillbirths were from intrauterine death (twins)
* 1 stillbirth was from intrauterine asphyxia, etiology unknown
* 1 stillbirth was from intrauterine asphyxia due to maternal drug use
* 1 stillbirth was from intrauterine hypoxia, etiology unknown

Ages of mothers
* 1 mother was 17 (no evidence of substance abuse)
* 1 mother was 22 (history strongly suggests mother used substances during pregnancy)
* 2 mothers were 36 (both mothers were substance users during pregnancy)

County
* 3 stillbirths occurred in Cook County
* 2 stillbirths occurred out-of-state, but case management was in Cook County

Accident

There were a total of 25 deaths ruled accident. The specific causes are detailed below.
* 1 child drowned at a park site under construction
* 1 child choked on a hot dog
* 4 children were struck by vehicles
* 7 children died in apartment/house fires
* 3 children suffocated when trapped between surfaces
* 1 child suffocated in his bed
* 1 child suffocated when his tracheostomy tube dislodged
* 6 children died sleeping with their parents or siblings
  Substance abuse appears to have been a factor in at least one of the deaths
* 1 child died from overheating after he was wrapped in too many blankets

Ages of Children
* 9 children were under six months
* 1 child was six months to one year
* 6 children were one to three years
* 2 children were four years
* 2 children were five to seven years
* 2 children were eight to ten years
* 2 children were eleven to thirteen years
* 1 child was fourteen years

County
* 17 of the deaths occurred in Cook County
  (3 of these were pronounced dead in Indiana)
* 2 occurred in Lake County
* 1 occurred in Madison County
* 2 occurred in Rock Island
* 1 occurred in Sangamon County
* 1 occurred in St. Clair County
* I occurred in Winnebago County

Substance Exposure at Birth
* 2 children were substance exposed at birth
  1 exposed to cocaine
  1 exposed to opiates

Substance Abuse in the Family of Origin
* 11 families had evidence of substance abuse

Natural

There were a total of 29 deaths ruled natural. The specific causes are detailed below.

* 5 deaths were from Sudden Infant Death Syndrome (SIDS); 2 of these were substance-exposed
* 3 deaths were from prematurity
* 3 deaths were from prematurity with maternal drug use
* 1 death was from prematurity and brain hemorrhage
* 2 deaths were from multiple medical problems
* 2 deaths were from Gangliosidosis, also called Tay Sachs disease
* 1 death was from bronchopneumonia
* 1 death was from to pneumonia and hypoxyencephaly
* 1 death was from Respiratory Syncytial Virus
* 1 death was from respiratory failure due to adenovirus with maternal substance abuse
* 1 death was from global multicystic encephalopathy due to anoxia as a consequence of apnea
* 1 death was due to hyperplastic lung
* 1 death was due to respiratory disease, not otherwise specified
* 1 death was from complications of cerebral palsy
* 1 death was due to disease of gastrointestinal system, not otherwise specified
* 1 death was due to dilated cardiomyopathy and obesity
* 1 death was due to congenital abnormalities and cardiomyopathy
* 1 death was from myocarditis and bronchopneumonia
* 1 death was due to sepsis

Ages of Children

* 11 children were under one month
* 7 children were one to six months
* 2 children were one year
* 3 children were two years
* 1 child was three years
* 1 child was eight years
* 1 child was twelve years
* 1 child was thirteen years
* 2 children were sixteen years

County

* 21 deaths occurred in Cook County
* 1 death occurred in Kane County
* 1 death occurred in Lake County
* 1 death occurred in LaSalle County
* 1 death occurred in McHenry County
* 1 death occurred in Montgomery County
* 1 death occurred in Peoria County
* 1 death occurred in Rock Island County
* 1 death occurred in Sangamon County

Substance Exposed at Birth

*12 children were substance exposed at birth
- 10 exposed to cocaine
- 2 exposed to polysubstances

Substance Abuse in the Family of Origin

* 16 families had evidence of substance use
  - 13 families had cocaine users
  - 2 families had polysubstance users
  - 1 family had alcohol users

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

Case #1 DOD July 1999
Age at death: 3-1/2 years
Substance exposed: yes, PCP
Cause of Death: Multiple injuries
Perpetrator: mother's boyfriend
County: Cook
Narrative: Three-and-a-half year old child was beaten to death by his mother's twenty-two-year-old boyfriend. The child's twenty-three-year-old mother left him in the care of her boyfriend while she was away from home for four days using drugs. Both the mother and her boyfriend were charged in the child's death. The mother has a history of DCFS involvement dating back to 1992 when two children were removed from her custody. The deceased, and a twenty-month-old sister, were allowed to remain at home with their mother following the deceased's PCP-exposed birth and subsequent reports to the DCFS hotline. The OIG conducted a full investigation of this child's death. A report was sent to the Director May 23, 2000.

Case #2 DOD August 1999
Age at death: 6 months
Substance exposed: no
Cause of Death: Multiple injuries
Perpetrator: mother
County: Cook
Narrative: Six-month-old was murdered by her eighteen-year-old mother. The baby's twin sister suffered severe head injuries. Their mother was indicated for the children's injuries and was charged with first degree murder and aggravated battery. The surviving twin is in the custody of DCFS. The mother had been a ward of DCFS from April 1995 to April 1999. In April 1999, three months after giving birth to the twins, the mother's wardship was terminated. At the mother's request, her guardian ad litem petitioned the court to close the mother's case. This case is being investigated by the OIG and a report to the Director is expected.

Case #3 DOD August 1999
Age at death: 2 years
Substance exposed: no
Cause of Death: Multiple injuries
Perpetrator: mother's boyfriend
County: Cook
Narrative: Two-year-old child was found unresponsive by the boyfriend of his twenty-three-year-old mother. The child had multiple bruises on his body, skin missing on the bottom of his feet, possible burns, and old scars. The twenty-year-old boyfriend was charged in the child's death. There was a prior investigation involving this child in March 1999 for allegations of sexual penetration to the child by the boyfriend. The child had been brought to the hospital with a swollen penis and hospital personnel were concerned. Further testing indicated that the child had an infection. The physicians found no other signs of sexual abuse and the case was unfounded. A one-year-old surviving sibling is in DCFS custody and is placed with a relative. The goal is for him to return to his mother's custody.

Case #4 DOD August 1999
Age at death: 8 years
Substance exposed: yes
Cause of Death: Multiple injuries
Perpetrator: foster father
County: Case management: Cook
Child's placement and death: Rutledge, Georgia
Narrative: DCFS took protective custody of the child after allegations of inadequate supervision, inadequate food, environmental neglect, cuts, welts and bruises, and medical neglect were indicated against her mother and father. While the child was in foster care, her father died and her mother's parental rights were terminated. The Department initiated efforts to get the child and her siblings adopted, and ultimately placed the child with her sister in a pre-adoptive home in Georgia through the Interstate Compact on the Placement of Children. Six months after placement in this pre-adoptive home, the eight-year-old child died after being beaten by the pre-adoptive father. The pre-adoptive father subsequently pleaded guilty to the child's murder and to charges of cruelty to children. An investigation of this case is pending and a report will be sent to the Director.

Case #5 DOD September 1999
Age at death: 13 years
Substance exposed: no
Cause of Death: stab wound to chest
Perpetrator: foster sister (another child in DCFS custody)
County: Cook
Narrative: Eleven-year-old ward was stabbed by a thirteen-year-old ward during an argument that took place in their foster home. The thirteen-year-old was charged with first degree murder and subsequently was found not delinquent on the charge by the Juvenile Court. The deceased came into DCFS custody in November 1996 after her mother was indicated for cuts, bruises, and welts to one of the child's siblings. The mother had involvement with DCFS dating back to 1987. The deceased had lived in the foster home for almost one year. She was due to return home shortly after the time of her death. The thirteen-year-old had lived in the foster home for two-and-a-half months. She came into foster care ten years ago after her mother was indicated for burns and cuts, bruises, and welts. The OIG conducted a full investigation of this case and a report was sent to the Director.

Case #6 DOD September 1999
Age at death: 8 years
Substance exposed: unknown
Cause of Death: Multiple injuries
Perpetrator: mother's live-in boyfriend
County: Johnson
Narrative: Eight-year-old boy was beaten to death by his thirty-two-year-old mother's twenty-eight-year-old fiancé over the course of two weeks. There was a prior investigation involving the family and an intact family case had been opened for several weeks, but was closed three months prior to the child's death. The OIG completed a full investigation of this case and a report was sent to the Director on June 16, 2000. *A more comprehensive narrative of this case can be found in the Investigations section of this annual report.*

Case #7 DOD October 1999
Age at death: 3 years
Substance exposed: unknown
Cause of Death: Head trauma
Perpetrator: mother
County: Cook
Narrative: An A-sequence report alleging inadequate supervision was pending at the time of the child's death. In August 1999, a Sheriff's deputy called the hotline to report that he had found a ten-year-old and a three-year-old home alone when he went to serve an eviction notice. The deputy also called the police who responded immediately and called the mother at work who returned home and left with the children before DCFS reached the home. DCP made several attempts by phone, letters and in person to reach the mother with no success. On October 11, 1999, the child was brought to the emergency room with massive head injuries. She died three days later. The A sequence was eventually indicated on the twenty-seven-year-old mother for inadequate supervision and the B sequence was indicated on the mother for cuts, welts and bruises, death by abuse, death by neglect, subdural hemotoma by neglect, inadequate supervision, and risk of harm. The surviving child is in the custody of DCFS.

Case #8 DOD November 1999
Age at death: 13 years
Substance exposed: no
Cause of Death: Gun shot wound to leg
Perpetrator: unknown gang member
County: Cook
Narrative: Thirteen-year-old ward left his group home with two other wards to visit a female classmate. On leaving the girl's home, the boys were confronted by five gang members and began running. While running, one of the gang members shot and killed the ward. The ward had been in the custody of DCFS since August 1994 because of neglect as a result of his mother's substance abuse. There are five surviving siblings, two of whom were born substance-exposed. Four of the children are in the subsidized guardianship of a relative. The fifth lives with the same relative, but has a goal of independence.

Case #9 DOD December 1999
Age at death: 3 years
Substance exposed: no
Cause of Death: Subdural hematoma
Perpetrator: mother
County: Cook
Narrative: An A sequence report for cuts, welts and bruises was pending at the time of the three-year-old's death. A doctor called the hotline on November 13, 1999 to report suspected abuse when upon examination he found multiple bruises on the child. Several other calls were made to the hotline regarding this family, prior to the child's death; all of the calls were taken as related information to the A sequence report. On November 30, 1999, hospital staff called the hotline to report that the child had been admitted with a subdural hematoma and brain damage, as well as several other old and new injuries. The child died on December 4, 1999. She suffered medical problems from the time of her birth and was diagnosed with Turner's Syndrome. The OIG is conducting a full investigation of this case and a report will be sent to the Director.

Case #10 DOD December 1999
Age at death: 6 years
Substance exposed: no
Cause of Death: Blunt head trauma
Perpetrator: step-father
County: Champaign
Narrative: Six-year-old boy was found unconscious by fire department personnel who were called to the home. The boy's step-father reported that the child had run into a bird cage. The child was taken to the hospital where doctors told police they did not expect him to live because of massive cerebral edema. Police were suspicious because the home was too cluttered for the child to have been running. The twenty-five-year-old step-father later admitted that he had hit the boy in the head three times because he was not getting ready as he had been told. The child had been in foster care approximately one year earlier. In March 1998, the hotline received a report alleging cuts, welts, and bruises to the boy by his step-father. The boy had bruises on his back and face. He was taken into custody by DCFS and placed with his maternal grandmother. The step-father was indicated on the report. The child was returned home after his mother and step-father participated in services. Their case was closed in December 1998. The OIG's investigation of this case is pending and a report will be sent to the Director when it is completed.

Case #11 DOD December 1999
Age at death: 11 years
Substance exposed: no
Cause of Death: Gun shot wound to head
Perpetrator: 16 year old youth
County: Cook
Narrative: Sixteen-year-old pulled out a .32 caliber revolver and pointed it at an eleven-year-old while they were at a friend's house. The gun discharged, hitting the eleven-year-old in the head. He died the following day. The police determined that the child's death was an accident, however, two youths were charged in his death. An eighteen-year-old convicted felon was charged with unlawful use of a weapon for possessing the gun and the sixteen-year-old was charged with involuntary manslaughter for causing the death. The eleven-year-old was a ward of the Department who had been on run from his foster home for eleven days. He came into the custody of DCFS in November 1999 because of neglect as a result of his mother's substance abuse. He was an only child. A report on this child's death was sent to the Director on June 26, 2000.

Case #12 DOD January 2000
Age at death: nine weeks
Substance exposed: yes
Cause of Death: Cocaine intoxication
Perpetrator: mother
County: Cook
Narrative: Nine-week-old baby died from cocaine intoxication. His thirty-year-old other was indicated by DCFS on the child's death. She also was arrested and charged with murder. At the time of the baby's death, the mother had an intact family case with the Department that was opened in January 1999 following the birth of a substance-exposed infant. Neither of the deceased's siblings is with their mother. The ten-year-old is in the custody of her father and the two-year-old is in foster care with a relative.

Case #13 DOD January 2000
Age at death: 19 years
Substance exposed: no
Cause of Death: Gun shot wound to head
Perpetrator: unrelated 28 year old woman
County: Cook
Narrative: Nineteen-year-old ward was shot in the head and killed while sitting in a car in a parking lot. The sister of the father of the ward's baby was arrested and charged with two counts of first degree murder. The nineteen-year-old ward had been in the custody of DCFS since February 1996 when her father was indicated for cuts, welts, bruises, and bone fractures. Her case remained open at the time of her death, as the court extended wardship until her 21st birthday based upon her need for services including parenting teen services. The ward had given birth to a daughter in February 1998. The ward's goal was substitute care pending independence and she and her daughter were placed in an independent living apartment. The ward had been visiting her aunt and uncle at the time of the incident. The ward's daughter is living with the ward's aunt and uncle who plan to adopt her.

Case #14 DOD February 2000
Age at death: 16 months
Substance exposed: no
Cause of Death: Subdural hematoma due to blunt head trauma
Perpetrator: Mother's boyfriend
County: Cook
Narrative: Sixteen-month-old child was killed by his mother's boyfriend. There was evidence that the boyfriend had abused the boy in the past. Therefore, both the twenty-two-year-old boyfriend and twenty-year-old mother were indicated in the child's death and charged with first degree murder. The family had one prior contact with DCFS. In July 1999, the mother was investigated on an allegation of inadequate supervision for leaving her children with a friend and failing to pick them up. The investigation was unfounded.

Case #15 DOD March 2000
Age at death: 2 months
Substance exposed: no
Cause of Death: Subdural hematoma and blunt trauma
Perpetrator: father
County: Cook
Narrative: Two-month-old baby boy was reportedly found on the floor by his father after he fell out of his car seat onto the floor from the couch. He was taken to the hospital where he died three days later. An autopsy revealed fractured ribs, bruises, cerebral hemorrhage and other head injuries. There was a prior investigation involving this baby in January 2000. An anonymous caller contacted the hotline to report that she heard the parents hitting the baby every night to keep him from crying. The baby's twenty-two-year-old mother denied hitting the child. The investigator observed the baby and noticed a couple of round red marks on the baby's shoulder and what appeared to be bruises on both thighs. The mother stated that she did not know what they were or how they got there. She agreed to take the child to the doctor the next day. The investigator returned to the home a couple of days later. The mother had taken the baby to the doctor and gotten a note written on the doctor's prescription pad. In the note the doctor said that the baby was seen in his office and that he had Mongolian spots on his back and thighs. The doctor wrote that there was no evidence of abuse or neglect and the investigation was unfounded.

Case #16 DOD March 2000
Age at death: 3 months
Substance exposed: no
Cause of Death: Blunt head trauma
Perpetrator: maternal grandmother
County: Cook
Narrative: Forty-two-year-old grandmother was babysitting her twenty-three-year-old daughter's three-month-old and five-year-old daughters. The grandmother confessed to killing the infant while she was high on crack cocaine. DCFS investigated the mother of the children in July 1999 for abuse to the five-year-old; the investigation was unfounded. The grandmother had an open DCFS case from July 1991 to January 1992. She has a lengthy and recent criminal history. She has been charged with first-degree murder.

Case #17 DOD March 2000
Age at death: 19 years
Substance exposed: no
Cause of Death: Cerebral injuries due to blunt trauma
Perpetrator: unknown
County: Cook
Narrative: Nineteen-year-old was found by the police unconscious and badly beaten on a sidewalk on January 18, 2000. He was in a coma until he died on March 25, 2000. The teen was a ward who had been in the custody of DCFS since September 1994. The teen had been placed with relatives, but eventually was placed at a residential facility. He had been admitted to a psychiatric hospital on occasion. In April 1999, the teen was placed with his father who requested that his son's case remain open to receive services.

Case #18 DOD April 2000
Age at death: 17 years
Substance exposed: no
Cause of Death: strangled
Perpetrator: unknown
County: Case management: Cook
Child's death, Detroit, Michigan
Narrative: Seventeen-year-old was on run at the time of her death. Her body was found in Detroit, Michigan, where the police had picked her up previously for prostitution. The teen and her two siblings had been removed from their mother's custody in 1995 because of allegations of inadequate shelter and environmental neglect. The teen's case is being reviewed as part of a study of whether the Department is responding appropriately in cases of wards on run.

Case #19 DOD June 2000
Age at death: 9 months
Substance exposed: no
Cause of Death: Drowning
Perpetrator: father
County: Cook
Narrative: Nine-month-old baby was beaten by his twenty-three-year-old father and had his head held under running water from a faucet until he drowned. There was a prior investigation involving the baby. In November 1999, a hospital contacted the hotline to report an allegation of cuts, welts, and bruises to the baby. The father was indicated on the report. The parents separated and the father had supervised visits with the baby and his two-year-old sibling. On the day of his death, the baby's twenty-seven-year-old mother left him and his sibling in the care of

their father unsupervised. The father was indicated for death by abuse and the mother was indicated for inadequate supervision and substantial risk of physical injury. The two surviving children, ages three and six, are in the custody of DCFS. The father has been charged with murder.

Case #20 DOD June 2000
Age at death: 5 months
Substance exposed: no
Cause of Death: Shaken Baby Syndrome
Perpetrator: unknown
County: St. Clair
Narrative: Five-month-old baby was brought to a hospital in St. Louis with skull fractures, orbital fractures, cerebral edema, and bleeding. He died shortly after arrival. There was a pending A sequence investigation at the time of the child's death against the baby's twenty-five-year-old mother and his babysitter. The investigation was initiated in April 2000 when the baby suffered a fractured arm. The DCP investigation of the child's death is still undetermined.

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

Case #21 DOD February 2000
Age at death: 16 years
Substance exposed: no
Cause: Gun shot wound to head
County: Sangamon
Narrative: Sixteen-year-old entered the custody of DCFS in May 1997 after his parents locked him out of the home. While in DCFS custody, the teen had numerous psychiatric admissions and threatened to commit suicide on several occasions. He was diagnosed with major depressive disorder and conduct disorder. He was returned to his parents' custody in January 2000. Three weeks later, the teen was discovered by his father in the bathroom with a self-inflicted gun shot wound to the head. The teen had broken a dead bolt lock on his parents' bedroom door to get the gun they kept in a drawer.

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

Case #22 DOD July 1999
Age at death: 2-1/2 months
Substance exposed: no
Cause of Death: undetermined
County: Cook
Narrative: Two-and-a-half month old infant was found unresponsive by his mother who stated that she went to sleep with the baby in her arms and when she woke up the baby was not responding. The baby was pronounced DOA at the hospital. Further investigation of his death revealed significant signs of malnutrition. He was well below the 5th percentile in weight. In a B sequence case, the mother was indicated for death, substantial risk of physical injury, and malnutrition. The mother was indicated in an A sequence investigation for substantial risk of physical injury after police came to a relative's home after being called because of the mother's

disorderly conduct and intoxication. Police felt the child was at risk of harm considering the mother's behavior and apparent neglect of the child. DCFS indicated the case ten days prior to the baby's death, but were unable to locate the mother to initiate services until after the baby's death.

Case #23 DOD October 1999
Age at death: 3 months
Substance exposed: no
Cause of Death: acute asphyxial event
County: Effingham
Narrative: Three-month-old baby was found unresponsive. This baby was the seventh child of his forty-four year old mother. An autopsy revealed that the baby had alcohol in his system. He is believed to have suffocated, but the manner of his death is still undetermined. The baby's mother has a history with DCFS dating back to 1980. The mother has been indicated on numerous reports of neglect as a result of her addiction to alcohol. One of her children has aged out of the system. Five of the children were in the custody of DCFS, but are now living with their thirty-eight-year-old father. Following the baby's death, the mother disappeared.

Case #24 DOD November 1999
Age at death: 2 weeks
Substance exposed: yes, cocaine
Cause of Death: undetermined
County: Cook
Narrative: Two-week-old baby was found unresponsive. At the time of his death, a B sequence investigation was pending as the baby was born substance-exposed. The deceased was the thirty-one-year-old mother's second substance-exposed infant. The family had an intact family case open from July 1996 to July 1997 after the mother delivered her first substance-exposed infant. At the time of the baby's death, the family was living with the maternal grandmother. The family was uncooperative with routine investigations of the baby's death by the police and the Office of the Cook County Medical Examiner. The surviving children, ages four and fourteen, were taken into custody in April 2000 during the investigation of the baby's death.

Case #25 DOD December 1999
Age at death: 3 years
Substance exposed: unknown
Cause of Death: undetermined
County: Cook
Narrative: Three-year-old boy was found unresponsive in his bed about 4:45 a.m. by his foster mother who is his great-maternal aunt. The foster mother reported that the child had had a low grade fever. She gave him Tylenol and the child went to sleep in his own bed. He was last seen at 12:30 a.m. The child had a history of two seizures: one at a year old and the other in October 1999. Both were related to high fevers. There were other children in the child's room, but no one could report what happened to the child. There are seven surviving siblings, none of whom are in the custody of their twenty-seven-year-old biological mother who has had an open case with the Department since January 1992.

Case #26 DOD January 2000
Age at death: 6 weeks
Substance exposed: no
Cause of Death: undetermined
County: Cook
Narrative: Six-week-old baby of a ward was found by his twenty-four-year-old father face down on the floor of his parents' hotel room on New Year's Day. His parents had gotten the room to celebrate the holiday and placed the child to sleep on a chair that was pushed up against a desk and a wall, leaving one side of the chair open. Both parents admitted to drinking that night and do not recall checking on the baby until the morning when they called 911. The baby was pronounced dead at the hospital. This was the second death of a child of this couple. Another baby boy was found unresponsive by his father in his stroller when he was four months old. As with the second baby, an autopsy revealed no apparent cause of death. According to the Cook County Medical Examiner's Office, two unexplained infant deaths in one family is extremely unusual and highly suspicious for foul play. The twenty-year-old mother has a three-year-old son who was taken into custody following the death of this child. He remains in the home of a relative.

Case #27 DOD January 2000
Age at death: 1-1/2 years
Substance exposed: yes, cocaine
Cause of Death: Blunt force trauma
County: Sangamon
Narrative: Twenty-month-old child was found by her foster mother on the floor near her highchair. The forty-five-year-old foster mother, who was the child's paternal aunt, said she had been in another room and heard a thud, and she found the child unconscious and believed she had fallen out of her chair. The child was rushed to the hospital and placed on life support with severe head injuries. She was pronounced dead two days later. Police began investigating the incident and arrested the children of the foster parent for trying to prevent the police from securing the home to collect evidence. Pediatricians at the hospital suspected shaken baby syndrome because of retinal hemorrhages and brain swelling that required surgery. According to the pediatricians, the surgery revealed older brain injury, as well as more acute damage. At a coroner's inquest, the pathologist and an ocular pathologist said that the blunt force to the head was compatible with a fall from a chair. The three pediatricians who treated the toddler at the hospital disagreed. One stated that the injuries were consistent with a fall from thirty stories or shaken baby syndrome. The coroner's jury came back with an open verdict. The child's biological family first came to the attention of DCFS in April 1998 when the child was born positive for cocaine. An intact family case was opened at that time. However, the thirty-two-year-old mother did not cooperate with drug treatment and her children were taken into custody in October 1998. The deceased child was placed with her paternal aunt. The mother gave birth to another cocaine positive baby in December 1999. A third baby was born in November 2000 and a report was accepted by the hotline for substantial risk of physical injury. That report is still pending. DCFS indicated the foster mother for death, subdural hematoma, and internal injuries by abuse. No criminal charges have been lodged.

Case #28 DOD January 2000
Age at death: 2 months
Substance exposed: no
Cause of Death: undetermined
County: Kankakee
Narrative: Two-month-old baby was found unresponsive in her car seat at her mother's home. An autopsy revealed no apparent cause of death and a coroner's jury ruled the death undetermined. This is the second death of a child of the parents. Another child died at the age of five months. An autopsy on that child revealed epidural hemorrhages indicative of abuse, but which did not cause the child's death. The mother lived with her sister at the time of the death and both of the women's children were taken into care following the first child's death. Between the two women there are three deceased infants within eighteen months. The sister had an infant child die in November 1997. The cause of death was determined to be pneumonia. Both women had open DCFS cases at the time of this child's death. DCFS had been unable to locate the mother and did not know of the baby's birth. The mother's oldest child had been taken into custody and was eventually placed with her father. The sister has had her children returned to her, but a case remains open with a private agency.

Case #29 DOD February 2000
Age at death: 0
Substance exposed: unknown
Cause of Death: undetermined
Perpetrator: mother
County: Vermilion
Narrative: Twenty-four-year-old woman gave birth to her fifth baby whom she reported did not make noise when it was born. The baby was found wrapped in a blanket in a duffle bag in a housing complex's laundry room. An autopsy revealed the baby had six fractured ribs. This was the mother's second baby to die under suspicious circumstances. In December 1997, the mother gave birth to a baby in a toilet and then hid the baby's body in a closet. An autopsy determined that the baby was dead at birth. Following the first baby's death, an intact family case was opened on the mother and her two children, then ages one and four. In January 1999, the mother gave birth to another baby which she gave up for adoption. The mother has been indicated for death by neglect on the death of the second baby. Her two surviving children are in the custody of DCFS.

Case #30 DOD February 2000
Age at death: 3 months
Substance exposed: no
Cause of Death: undetermined
County: Cook
Narrative: Three-month-old baby was found unresponsive at home by his mother and was rushed to a hospital by ambulance. The mother had been to the hospital earlier that morning for treatment for herself and had brought the child along. The child appeared fine at that time. There had been a report to the hotline a month earlier for substantial risk of physical injury and failure to thrive. The mother had been involved in domestic violence and had not followed through on medical appointments for the baby. The case was indicated five days prior to the baby's death, but a DCFS follow-up case had not yet been opened.

Case # 31 DOD February 2000
Age at death: 3 months
Substance exposed: yes, cocaine
Cause of Death: undetermined
County: Cook
Narrative: Three-month-old baby was found unresponsive in the morning by her mother. She was laying on her stomach with her face to the side on a twin sized bed. The baby was the ninth child of the thirty-year-old mother. The mother's other children are in the custody and guardianship of their maternal grandmother. The A sequence report came in on the birth of the deceased infant when she and the mother tested positive for drugs. The mother agreed to drug treatment and called a treatment facility to set up detoxification. The mother also called her sister who agreed to let the mother and the baby live with her and provide care for the baby so long as the mother engaged in treatment. The mother attended an initial meeting at the treatment center with the investigator and planned to enter the facility in the next few days after the baby was released from the hospital. Once the baby was released from the hospital, the mother went to her sister's home, took the baby, and left. The sister called DCFS initiating a B sequence report and the investigator searched for the mother and baby. DCFS was unable to locate the mother and baby prior to the baby's death. The medical examiner's office also was unable to locate the mother for a scene investigation. The mother has no children in her care.

Case #32 DOD February 2000
Age at death: 2-1/2 months
Substance exposed: yes, opiates (but due to prescribed Tylenol with codeine)
Cause of Death: Dehydration, bronchopneumonia, child neglect
County: Cook
Narrative: Two-and-a-half-month old baby stopped breathing while her mother attempted to bottle-feed her. The baby was taken to the hospital and pronounced dead. The baby's death was reported to the hotline as a B sequence. The medical examiner eventually ruled the cause of death as dehydration, bronchopneumonia and child neglect, but the manner of the child's death was undetermined. The medical examiner's office felt that the pneumonia and dehydration should not have gotten as bad as it did. The mother had taken the child to the hospital five days before her death because of coughing and sneezing. The baby was seen at the emergency room, and the mother was instructed to take the baby to her regular pediatrician within 24 hours or return to the emergency room if the baby had trouble breathing or ran a fever. The mother did not take the baby to the doctor. This baby was the twenty-three-year-old mother's fifth child. She had no DCFS involvement until the deceased child was born in December 1999 and tested positive for opiates. The mother stated that she had been prescribed Tylenol 3 with codeine for pain after she went into premature labor. The mother's physician confirmed this and the case was unfounded. During the course of the B sequence investigation, the mother voluntarily gave custody of her children to their godmother. DCFS indicated the mother for death by neglect.

Case #33 DOD March 2000
Age at death: 2 months
Substance exposed: no
Cause of Death: undetermined
County: Cook
Narrative: Two-month-old baby was found cold and unresponsive in his car seat by his mother in the morning. The parents took the baby to the hospital where it was pronounced DOA. The mother has an extensive DCFS history. The baby's death was reported to the hotline as an H sequence. It was unfounded for death by neglect. The A sequence was reported in December 1993 when the mother gave birth to a baby showing signs of withdrawal. The case indicated for

substance misuse. The B and C sequences were reported in August 1994 when the mother left her two children with a relative and did not return, and then got the children and left them alone. An intact family case was opened based on those reports. The D sequence was reported in October 1994 when the mother again left her children with an adult but did not return to pick them up. A voluntary placement agreement was worked out, and in May 1996, the DCFS case was closed. The case reopened in May 1996 after the F sequence was reported to the hotline alleging that the mother was not providing aid to the relative taking care of her children. At that time, DCFS took the children into custody and they were placed in relative foster care. The G sequence was reported in January 2000 when the deceased child was born and the mother tested positive for cocaine and for substantial risk of physical injury due to the other children being in DCFS care. The case was indicated, but the child remained with the mother as she agreed to participate in services. In July 2000, the goal for the children in care was changed to substitute care pending termination of parental rights.

Case #34 DOD March 2000
Age at death: 7 months
Substance exposed: yes, opiates
Cause of Death: undetermined
County: Cook
Narrative: Seven-month-old baby was found unresponsive by family members on the floor next to a bed. There was no crib for the baby in the home. The police and fire department were called and the baby was pronounced dead. The police and medical examiner have different stories from family members as to who was home when and how exactly the baby was found. The baby was in foster care with his twenty-one-year-old maternal aunt who has two of her own children. The maternal grandmother, who lived in the same building, was the designated daycare provider, but was unable to care for the child on the day of his death. The aunt apparently left the baby in the care of a twenty-one-year-old cousin, and another thirteen-year-old girl also babysat for the child. The baby was born substance-exposed to a thirty-year-old mother and was taken into custody immediately. The infant was the mother's seventh drug exposed baby. The first was born in 1991. All the children had been taken into custody and relatives came forward to provide foster care for them. The baby was generally healthy for a substance exposed infant. However, he was small. The baby had been gaining small amounts of weight, but his weight at death indicated that he lost a pound in the last four days of his life.

Case #35 DOD April 2000
Age at death: 6 weeks
Substance exposed: yes, alcohol and cocaine
Cause of Death: undetermined
County: Jefferson
Narrative: The six-week-old infant was brought to the hospital in critical condition with blood in her lungs. The hospital called the hotline and an I sequence report was taken and later unfounded. The H sequence was pending at the time of the baby's death and was later indicated for substantial risk of physical injury. It had been reported four days prior to the baby's death that the mother was in a car accident with the children in the car and the mother was charged with a DUI. The G sequence report was indicated in May 1999 after the mother drank to the point of passing out in a taxi with the children present. The B sequence report was indicated in May 1992 after the mother give birth to a baby testing positive for cocaine. The twenty-eight-year-old mother has had two intact family cases open with DCFS. The first case was open from May 1992 to September 1992. The second case was open January 1999 to March 1999. The mother has five surviving children who were in custody from May 2000 to October 2000. They are currently at home receiving intact family services.

Case #36 DOD April 2000
Age at death: 7 months
Substance exposed: no
Cause of Death: undetermined
County: Cook
Narrative: Seven-month-old baby was found unresponsive in his crib by his father. The baby was sharing the crib with his twin brother. The thirty-six-year-old father was caring for the children; the thirty-four-year-old mother was not home at the time. The mother of the twins has an eight-year-old daughter. The mother has had several cases open with the Department. The first case, an intact family case, was open from September 1993 to February 1995. The second case was open from August 1999 to September 1999 when the oldest child was in custody (this was around the time of the twins' birth). The third case opening was from February to March 2000. In July 2000, the mother was indicated for inadequate supervision of the children and another intact family case was opened.

Case #37 DOD June 2000
Age at death: 6 months
Substance exposed: no
Cause of Death: undetermined
County: Winnebago
Narrative: Six-month-old infant was found unresponsive by his twenty-nine-year-old mother. The infant was the fifth child born to this mother who has a history of DCFS involvement dating back to 1991. The mother was an indicated perpetrator on nine reports of abuse and neglect involving her children from 1991 to 1999. This child was the second of the mother's five children to die. The first child died in December 1994. His death was ruled a SIDS. The second child's death was ruled undetermined; although there was no apparent cause of death for the child, two SIDS deaths in one family are highly unlikely. The mother was indicated on the baby's death as the baby was supposed to be on heart and apnea monitors and was not. The mother does not have any children in her custody. One child was adopted in 1997. The other two children were removed from her custody in June 2000 following the baby's death.

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

Cases #38 and #39 DOD July 1999
Substance exposed: unknown
Cause of Death: Intrauterine death
County: Case management: Cook
Child deaths: Milwaukee, Wisconsin
Narrative: Seventeen-year-old mother, who is a ward of DCFS, delivered stillborn twins in Milwaukee, Wisconsin while on run from her group home in Cook County. The teen parent has been in the custody of DCFS since August 1997. She has one surviving child, a daughter, born in January 1998, who is not a ward of the Department. The teen is currently in an independent living program with her child.

Case #40 DOD September 1999
Substance exposed: yes, cocaine
Cause of Death: Intrauterine asphyxia, etiology unknown
County: Cook
Narrative: Thirty-six-year-old mother gave birth to fetus of approximately five months gestation while on the toilet at home. Mother put deceased fetus down her pants leg and accompanied her boyfriend to his grandson's baseball game where she smoked cocaine. This was the mother's ninth pregnancy; she has had five live births, two miscarriages, and one prior stillbirth. This stillbirth was the mother's third substance-exposed baby. The mother has had an open DCFS case since July 1994. At the time of the baby's death, the five children ranged in age from four to twenty. The three youngest are in foster care, one is in subsidized guardianship, and the oldest has been emancipated.

Case #41 DOD December 1999
Substance exposed: yes, cocaine
Cause of Death: Intrauterine asphyxia due to maternal drug use
County: Cook
Narrative: Thirty-six-year-old mother admitted to using cocaine throughout her 34 week pregnancy. She partially delivered the baby at home, the fetus was not viable. The mother entered the hospital under the influence of cocaine and heroin. She has nine other children and has been involved with DCFS since September 1986. At the time of the baby's death, the children ranged in age from four to twenty. Three of the children have been adopted; two are in subsidized guardianship; two are in foster homes; a seventeen-year-old is on run; and the oldest has been emancipated.

Case #42 DOD March 2000
Substance exposed: presumed yes
Cause of Death: Intrauterine hypoxia
County: Cook
Narrative: Twenty-two-year-old mother delivered stillborn of five months gestation at home. Mother has three children who were 9 months, 1-1/2, and four years old at the time of the baby's death. The youngest two children were born substance exposed. All three children are in the custody of DCFS and the State is in the process of terminating parental rights.

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

Case #43 DOD July 1999
Age at death: 2-1/2 years
Substance exposed: no
25 yo mother not believed to use drugs
Cause of Death: aspiration of food (choking)
County: Cook
Narrative: Foster father, the mother's uncle took the child and his older brother and sister to visit their mother. While at their mother's home, the child ate and choked on a hot dog. CPR was attempted and 911 was called, but the child died en route to the hospital. The child entered the custody of the Department with his brother in August 1997 after their mother was indicated on a report of medical neglect and risk of harm. The children were placed in the home of their great

uncle where their older sister already lived by private arrangement. The twenty-five-year-old mother, who is not believed to use drugs, signed consents in October 1998 for her aunt and uncle, the boys' foster parents, to adopt them. The brother was adopted on 12/2/99.

Case #44 DOD July 1999
Age at death: 7 months
Substance exposed: no
Cause of Death: Asphyxia due to compression of neck due to trapping between mattress frame and couch
County: Cook
Narrative: Seven-month-old infant was found unresponsive by his grandmother in the morning wedged between the back of the couch and the couch cushion. The infant and his two siblings, ages one-and-a-half years and five years, were cared for overnight during the week by their grandmother and step-grandfather while their mother worked. At the time of the infant's death, there was a pending investigation of risk of sexual injury to the grandchildren by the step-grandfather based on an adult daughter's therapy in which she uncovered repressed memories of being sexually abused by her father. The report was subsequently unfounded as was a death by neglect report on the infant's death.

Case #45 DOD July 1999
Age at death: 11 years
Substance exposed: unknown
Cause of Death: Multiple injuries due to being struck by motorcycle
County: Cook
Narrative: Eleven-year-old was hit by a motorcycle while crossing the street with her great-grandmother and younger sister. The child, and her four siblings, had been returned to their twenty-nine-year-old mother's care five months earlier after three years in foster care because of neglect.

Case #46 DOD July 1999
Age at death: 10 years
Substance exposed: no
Cause of Death: Severe head injuries due to being struck by vehicle
County: Cook
Narrative: Ten-year-old child was struck by a vehicle. As she was attempting to cross the street, a vehicle slowed down and motioned for the child to cross. While she was crossing, a second vehicle approached the first vehicle, sped around the stopped vehicle, and struck the child as her grandmother watched. The child, and her two siblings, ages four and seven, had come into the custody of DCFS in May 1999 because of neglect as a result of their mother's substance abuse problem. They were placed with their maternal grandmother.

Cases #47 and #48 DOD August 1999
Ages at death: 5 and 3 years
Substance exposed: no
Cause of Death: Carbon monoxide intoxication due to house fire
County: Cook
Narrative: Twenty-two-year-old father and his two sons, five and three years, died in a house fire while visiting the children's paternal grandmother. The fire is believed to have been the result of faulty wiring. The children had been in the custody of DCFS and living with the grandmother from March 1997 to May 1997 as a result of medical and environmental neglect by their mother who was eighteen at the time. In May 1997 the children were returned home under court

supervision and DCFS provided services until February 1999 when the court case was closed. The children had since been living in Mississippi with their father.

Case #49 DOD September 1999
Age at death: 7 years
Substance exposed: no
Cause of Death: Multiple injuries due to being struck by vehicle
County: Cook
Narrative: Seven-year-old child was struck by a sports utility vehicle. The child had purchased ice cream from an ice cream truck across the street from her foster home. As she stepped in front of the ice cream truck, the child was struck by a sports utility vehicle. The child, and her two brothers, came into the custody of DCFS in October 1995 as a result of this child having a sexually transmitted disease for which the parents had no explanation. The children had lived with their maternal grandmother since coming into care. The mother and father, who were 27 and 29 at the time of this child's death, both have problems with substance abuse. They are working to complete services to get their sons returned to them.

Case #50 DOD September 1999
Age at death: 14 years
Substance exposed: unknown
Cause of Death: Multiple injuries due to hit and run
County: Sangamon
Narrative: Teen was found dead with a fourteen-year-old friend along the roadside in the early morning. The girls are believed to have been victims of a hit and run accident. The teen had been in the custody of DCFS since 1992 because of neglect by her mother who has a substance abuse problem. The teen had a history dating back to 1997 of running from her placements. Approximately three weeks prior to her death, the teen was located and placed in a group home; she ran from the placement that same day and was on runaway status at the time of her death.

Case # 51 DOD October 1999
Age at death: 6 months
Substance exposed: no
Cause of Death: Asphyxia due to trapping between mattress and wall
County: Cook
Narrative: Six-month-old baby was found unresponsive face down hanging halfway off the bed by his grandmother's friend. A scene investigation revealed that he suffocated after becoming trapped between the mattress and the wall. The baby had been staying with his grandmother for the weekend while his mother was away. The thirty-two-year-old mother has seven other children, none of whom are in her care. The family has been involved with DCFS since 1992 when a daughter was removed from her parents' custody after suffering a broken leg. Two more cases were indicated against the mother in 1997 and 1998 for inadequate supervision and medical neglect. Five children living with the mother were taken into custody in August 1998. Another child lives with his father. When the baby was born, the court allowed him to remain with his mother while services were provided. The mother has a mental illness and a history of substance abuse, but was making progress in services.

Case #52 DOD November 1999
Age at death: 6 weeks
Substance exposed: no
Cause of Death: Positional asphyxia
County: Family residence: Cook
Child's death: Lake County, Indiana
Narrative: Six-week-old baby was found unresponsive by her mother. The baby was sleeping in bed with her thirty-nine-year-old mother and thirty-eight-year-old father. The mother has five children, ages three to seventeen at home, and a history of DCFS involvement from 1984 to 1993. In February 1999, the mother was indicated on a report of cuts, bruises, and welts to her nine-year-old son, but a service case was not opened following the report.

Case #53 DOD November 1999
Age at death: 3 months
Substance exposed: yes, cocaine
Cause of Death: Positional asphyxia
County: Family residence: Cook
Child's death: Lake County, Indiana
Narrative: Three-month-old baby was found unresponsive by his foster mother in his foster home. The foster mother rushed him to the hospital in Lake County, Indiana. The foster mother reported that the child had a cold the day prior to his death. The baby had been laid down to sleep in his bassinet on his stomach, reportedly because of a medical condition that precluded him from sleeping on his back. DCFS records indicate that the foster parent was very attentive to the baby's health. The baby's biological mother was first indicated on a report in January 1996 when she gave birth to a baby testing positive for cocaine. An intact family case was opened at that time. The children came into custody and were placed with relatives in August 1996 because of continued neglect. The deceased came into DCFS custody following his substance-exposed birth.

Case #54 DOD November 1999
Age at death: 6 weeks
Substance exposed: unknown
Cause of death: Positional asphyxia
County: Family residence: Cook
Child's death: Lake County, Indiana
Narrative: Six-week-old baby was found unresponsive by his thirty-three-year-old mother. The mother had been laying on the couch with the baby. The mother was the indicated perpetrator on two prior reports. In October 1995 she was indicated after giving birth to a substance-exposed infant. In November 1998 she was indicated for giving a substance to her children ages three and five. She had an open intact family case from October 1995 to May 1997 and from November 1998 to July 1999. Following the baby's death, the mother was indicated again, in February 2000, for inadequate supervision and inadequate shelter to her two surviving boys, ages five and seven. At that time, she transferred guardianship of the boys to their paternal grandmother.

Case #55 DOD December 1999
Age at death: 12 years
Substance exposed: no
Cause of Death: Burns due to house fire
County: Cook
Narrative: Twelve-year-old child was sleeping in the attic of her sixteen-year-old boyfriend's home when a space heater caught on fire. At the time of the child's death, there was a pending A

sequence investigation on the child's thirty-eight-year-old mother. Allegations included environmental neglect, inadequate supervision, and risk of harm to the deceased's siblings because of the mother's substance abuse.

Cases #56 and #57 DOD December 1999
Ages at death: 2-1/2 and 4 years
Substance exposed: no
Cause of Death: Burns due to apartment fire
County: Lake
Narrative: Two children died in an apartment fire while left home alone by their forty-seven-year-old grandmother. The grandmother was the boys' guardian; their mother died from cancer a year earlier. Three days prior to the fire, DCFS received a report alleging environmental neglect and inadequate supervision by the grandmother who was reported to be an alcoholic. The report was being investigated at the time of the boys' deaths. The inadequate supervision allegation was later indicated. The grandmother was also indicated on the children's deaths. Her own children, ages eight and twelve, and an eight-year-old surviving sibling are in foster care with a relative. The goal is for them to return to the grandmother's care at some point in the future.

Case #58 DOD January 2000
Age at death: 15 months
Substance exposed: no
Cause of Death: Hyperthermia
County: Madison
Narrative: Fifteen-month-old died from hyperthermia after his mother's thirty-year-old boyfriend wrapped him tightly in several layers of blankets and laid him down for a nap before sitting down to watch a football game on television. At half-time, the boyfriend checked on the child and found him unconscious. A coroner's jury ruled the child's death an accident. The boyfriend was charged with involuntary manslaughter and endangerment of a child. He was acquitted of both charges by a jury in October 2000. Prior to this child's death, the family had two intact family cases with the Department. The first was open from September 1993 to March 1994 because of bruises on one of the children caused by his father. The second case was open from June 1999 to November 1999 after the twenty-seven-year-old mother left her ten-year-old daughter alone to care for her six-month-old brother. There was a third indicated investigation in July 1998 involving bruises to the oldest son caused by a different boyfriend. This indicated investigation did not result in a case being opened. The mother, and her three surviving children, are currently receiving intact family services from the Department.

Case #59 DOD January 2000
Age at death: 3 months
Substance exposed: no
Cause of Death: asphyxia by overlay
County: McHenry
Narrative: Three-month-old baby was found unresponsive by his thirty-four-year-old mother when she awoke from a nap they took together. The mother was indicated for death by neglect on the child's death. There was one prior investigation on this mother and child which was unfounded in December 1999. It was alleged that the mother attempted suicide and passed out. The investigation revealed that the mother has a seizure disorder and had been having difficulty maintaining her medication level. The child stayed with an aunt while the mother was hospitalized. The mother denied feeling suicidal and her physician stated in writing that she was not a risk to herself or her child. The deceased was the mother's only child.

Case #60 DOD February 2000
Age at death: 2-1/2 years
Substance exposed: no
Cause of Death: Positional asphyxiation due to being trapped under a chest of drawers
County: Winnebago
Narrative: Two-and-a-half-year-old child suffocated after being pinned under a chest of drawers that had fallen over. The child's twenty-six-year-old mother left her and her eleven-month-old brother in the care of their father while they were taking naps. When the mother returned home an hour-and-a-half later, she found her daughter pinned under the dresser. The twenty-five-year-old father, who has a history of drug use, had no idea what happened and is believed to have been under the influence of drugs at the time of the incident. The parents had two prior indicated reports of environmental neglect: one in April 1998 and one in September 1998. The family had an intact family case open from June 1998 to November 1999. The case was reopened for services following the child's death. There are three surviving children ages five, three, and two. The dresser is believed to have fallen because it was overstuffed with clothing. The mother was indicated for environmental neglect. The father was indicated for environmental neglect and inadequate supervision.

Case #61 DOD February 2000
Age at death: 3 weeks
Substance exposed: no
Cause of Death: Overlay
County: Cook
Narrative: Three-week-old baby was found unresponsive by her parents in the morning. Her father ran her to a hospital three blocks away where she was pronounced dead. After a scene investigation, it was determined that the baby, who was sleeping between her parents on a twin bed, was rolled over by one of her parents. The baby's mother, who was sixteen at the time of the baby's death, has been a ward of DCFS since January 1997. She has another child, who is now two-and-a-half-years old, who has been in the custody of DCFS since August 2000. The father of the baby, who was nineteen at the time of the baby's death, was a ward of DCFS from July 1993 to September 1994.

Case #62 DOD February 2000
Age at death: 4 months
Substance exposed: no
Cause of Death: Overlay
County: St. Clair
Narrative: Four-month-old baby was found unresponsive by her parents in the morning. She had been sleeping between her parents in their bed. Both parents had been out drinking the night before. The thirty-two-year-old mother and thirty-eight-year-old father were unfounded perpetrators on a December 1999 risk of harm report regarding the baby. Earlier, they voluntarily relinquished custody of their three older children to relatives in Indiana. The family had two prior indicated reports in Illinois: an August 1994 report of inadequate shelter and a December 1995 report of risk of harm. These were not detected at the time of the December 1999 report. Both parents were indicated for neglect in the death of the baby.

Cases #63 and #64 DOD February 2000
Ages at death: 4-1/2 and 1-1/2 years
Substance exposed: no
Cause of Death: Smoke inhalation due to apartment fire
County: Rock Island
Narrative: Twenty-nine-year-old mother left two of her children in the apartment alone while she went to pick up another child from the bus stop about 200 feet from the apartment. The children died in a fire that broke out in the apartment. The cause of the fire was not determined. The mother was indicated for death by neglect to the deceased and substantial risk of physical injury to her six surviving biological and step-children. The step-children were previously in the custody of DCFS because of neglect by their biological mother and excessive corporal punishment by their father. The children were returned to their father and step-mother's custody and their DCFS case was closed in July 1999.

Case #65 DOD April 2000
Age at death: 7 weeks
Substance exposed: yes, opiates
Cause of Death: Overlay
County: Cook
Narrative: Seven-week-old baby was found unresponsive by her mother in the morning lying on her stomach face down with her ten-year-old sister's leg across her head. The baby had been born with opiates in her system; her forty-one-year-old mother reported that she took Tylenol 3 for a toothache. At the time of the baby's death, DCFS was assessing the mother for substance abuse treatment.

Case #66 DOD May 2000
Age at death: 3 weeks
Substance exposed: no
Cause of Death: Overlay
County: Family residence: Rock Island
Child's death: Cook
Narrative: Three-week-old baby was found unresponsive in bed with her eighteen-year-old mother and twenty-two-year-old father. The grandmother, whom the family was visiting, awoke to find the mother had rolled over the baby in her sleep. The mother was a ward of the Department from May 1995 to April 1999. She has a second child who was a year old at the time of the baby's death. The mother was indicated on a July 1999 report of inadequate supervision of this child because she left him with a neighbor and did not return for him until well past the agreed upon time. The court decided not to place this child in the custody of DCFS following the baby's death. Both parents were indicated for neglect in the death of the baby.

Case #67 DOD June 2000
Age at death: 5 months
Substance exposed: no
Cause of Death: Asphyxia due to dislodged tracheostomy tube
County: Cook
Narrative: Five-month-old boy died in a pediatric nursing home. Three nursing home staff members were indicated for neglect in the child's death for failing to regularly check him and notice that his tracheostomy tube had dislodged. DCFS has since removed all of its wards from this facility. The infant was placed in the facility in May 2000 by his twenty-three-year-old mother and twenty-seven-year-old father who were indicated on an April 2000 substantial risk of physical injury report based on their care of the infant who was born premature and had medical

complications. The parents wanted the child placed in the facility because they were concerned about DCFS knocking on their door every time something went wrong with the infant's care. The parents have three other children, ages one, five, and seven, in their care.

Case #68 DOD June 2000
Age at death: 9 years
Substance exposed: unknown
Cause of Death: Drowning
County: Cook
Narrative: Nine-year-old boy drowned in a 17-foot-deep pit at a park site under construction. The child and some friends were at the park with his foster mother's adult daughter, who is also a licensed foster parent. Despite being warned by the foster parent to stay away from the site, the children crawled under a fence and the nine-year-old slipped in the mud and into the pit. Neighbors complained that the site was not fenced securely and children had been playing there for weeks. The child had been in the custody of DCFS since August 1995 because of neglect as a result of his mother's substance abuse problem. The mother has had all five of her children removed from her custody. Three of her children have been adopted and she is in the process of having her parental rights terminated on the youngest child.

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

Case #69 DOD July 1999
Age at death: 16 years
Substance exposed: unknown
Cause of Death: cerebral palsy, natural
County: Cook
Narrative: Sixteen-year-old child with cerebral palsy was found unresponsive by her thirty-five-year-old mother. An autopsy of the child revealed that she was dehydrated at the time of her death. Thus, the mother was indicated for medical neglect. The mother has three surviving children, ages one, three, and thirteen, in her custody. The family first came to the attention of DCFS in March 1999 when the mother gave birth to a substance-exposed infant. An intact family case was opened at that time and remains open.

Case #70 DOD August 1999
Age at death: 0
Substance exposed: yes, cocaine
Cause of Death: Hyperplastic lung
County: Peoria
Narrative: Twenty-nine-year-old mother gave birth to a baby at twenty-four weeks gestation. The mother and baby tested positive for cocaine. The baby died a few hours later. The mother first came to the attention of DCFS in April 1999 because of a domestic violence charge against the mother's boyfriend. The mother's two daughters were taken into custody in April 1999 because the boyfriend remained with the family. The boyfriend had a lengthy criminal history and had been found unfit in the care of another child. The boyfriend has since been sentenced to ten years in federal prison. The mother was indicated for substance misuse and death by neglect in the baby's death. The older children remain in care.

Case #71 DOD August 1999
Age at death: 12 years
Substance exposed: no
Cause of Death: Multiple medical problems
County: Cook
Narrative: Twelve-year-old child became a ward of the state in December 1987 when her mother abandoned her at the hospital. The child spent her entire life at a health care facility where she was placed because of her severe medical problems. The child suffered from congenital abnormalities, microencephaly, seizure disorder, asthma, profound mental retardation, and multiple allergies. She had a tracheostomy and gastrostomy. The child was on a ventilator and shortly before her death her respiratory problems had worsened.

Case #72 DOD August 1999
Age at death: 11 days
Substance exposed: yes, cocaine
Cause of Death: Prematurity
County: Cook
Narrative: Twenty-eight-year-old mother gave birth to a baby at 23 weeks gestation. The mother started labor three weeks earlier and was hospitalized to delay delivery of the baby. The mother admitted to using cocaine a few days prior to her hospital admission. She had been indicated on an inadequate supervision allegation three weeks earlier and an intact family case was opened. The mother entered outpatient substance abuse treatment two days prior to going into labor. She has four surviving children ages four to twelve and an intact family case remains open.

Case #73 DOD September 1999
Age at death: 0
Substance exposure: yes, cocaine
Cause of Death: Prematurity
County: Cook
Narrative: Twenty-four-year-old mother gave birth to a premature infant who died two hours after birth. The mother tested positive for cocaine. Seven months earlier, the mother was indicated on an inadequate supervision allegation after she left her one-and-a-half and three-year-old children with a relative and had not returned six weeks later. The children's grandparents filed for custody of them.

Case #74 DOD September 1999
Age at death: 1-1/2 years
Substance exposed: no
Cause of Death: Respiratory disease
County: Cook
Narrative: One-and-a-half-year-old child had chronic respiratory problems. Her twin was healthy. The child had 12-14 hours of nursing care per day in her home. She was in the hospital for five days prior to her death. An intact family case was open with DCFS from July 1998 to September 1999 because of an indicated report of medical neglect of the child. The child's twenty-three-year-old mother is not believed to use drugs.

Case #75 DOD October 1999
Age at death: 8 years
Substance exposed: no
Cause of Death: Multiple medical problems
County: Cook
Narrative: Eight-year-old boy had severe medical problems including asthma, abnormal and undeveloped lungs, heart strain due to pulmonary blood vessel disorder, tracheostomy, gastroesophageal reflux, G-tube, and severe food allergies. In October 1999, the child was hospitalized in respiratory distress. He was placed on a ventilator because he was unable to breathe on his own. Four days later, he went into cardiac arrest. Attempts to resuscitate him were unsuccessful. The child had been in the care of DCFS since August 1995 when his parents abandoned him. His parents' rights were terminated in 1996. The child lived in a foster home for children with special needs. His goal was adoption.

Case #76 DOD October 1999
Age at death: 4-1/2 months
Substance exposed: no
Cause of Death: global multicystic encephalopathy due to anoxia as a consequence of apnea
County: Sangamon
Narrative: Four-and-a-half-month-old baby was found unresponsive in the morning by his foster mother. The baby's apnea monitor had been turned off two days prior. The baby was supposed to be on the apnea monitor at all times when asleep. The forty-three-year-old foster mother was indicated for death by neglect and medical neglect because the apnea monitor was turned off. The baby entered foster care in September 1999 after he sustained brain damage and a skull fracture. His twenty-two-year-old mother was indicated for abuse and medical neglect related to his injuries.

Case #77 DOD October 1999
Age at death: 18 days
Substance exposed: yes, cocaine, heroin
Cause of Death: Respiratory failure due to adenovirus pneumonia; maternal substance abuse
County: Cook
Narrative: Eighteen-day-old substance-exposed infant died before he was able to leave the hospital. His thirty-three-year-old mother and thirty-two-year-old father had moved to Illinois from New Jersey where they had a long history with Youth and Family Services because of their history of drug abuse and inconsistent substance abuse treatment. In September 1998, based on their history, the parents were indicated for substantial risk of physical injury to their two and four-year-old daughters. They were also indicated for medical neglect of the four-year-old for failing to follow through on her immunizations. An intact family case was open from October 1998 until August 1999 when the children went to live with their grandfather in Puerto Rico.

Case #78 DOD October 1999
Age at death: 6 days
Substance exposed: no
Cause of Death: Brain hemorrhage, prematurity
County: Cook
Narrative: Six-day-old baby girl died from a hemorrhage in the brain. She had been born premature at 24 weeks gestation and never left the hospital. A C-sequence report was called into the hotline on the day of her birth. A report was taken for substantial risk of physical injury based on the twenty-six-year-old mother's prior history of abuse and neglect. In March 1997, the

mother was indicated for skull fracture by abuse, substantial risk of physical injury, and medical neglect. The mother's three surviving children are in foster care in relative placements.

Cases #79 and #80 DOD November 1999
Substance exposed: yes, cocaine
Cause of Death: Prematurity, maternal drug use
County: Cook
Narrative: Thirty-year-old mother delivered twins at 25 weeks gestation in the bathroom of her home after smoking cocaine. The mother has five other children, three live with their father and two have been adopted.

Case #81 DOD December 1999
Age at death: 1 month
Substance exposure: yes, cocaine
Cause of Death: SIDS
County: Cook
Narrative: One-month-old baby was found unresponsive in the morning in her bassinet by her twenty-two-year-old mother. The baby was taken to the hospital where she was pronounced dead. The family's first contact with DCFS was in November 1999 when a hotline call was made alleging that the mother had beat her five-year-old daughter with a belt in front of a classroom. This case was unfounded. A second call was made to the hotline eight days later when the deceased was born and tested positive for cocaine. The case was indicated and six days later an intact family case was opened. The intact family worker made five visits to the home and scheduled two appointments for the mother at a drug rehabilitation center. The baby was taken for a check-up a week after her birth and appeared to be doing fine. An intact family case remains open on the mother and her surviving daughter.

Case #82 DOD December 1999
Age at death: 3 weeks
Substance exposed: no
Cause of Death: SIDS
County: Cook
Narrative: Three-week-old baby was found unresponsive on an adult bed. The baby's mother first came to the attention of DCFS when an older child was admitted to the hospital for inorganic failure to thrive in September 1998. An intact family case was opened. The child was checked regularly for weight gain and the maternal grandmother helped to provide child care. The mother seemed to improve her interactions with her children and the sibling gained weight regularly. DCFS was helping the mother to find housing as she was living with her parents. DCFS did not know that the mother was pregnant with the baby. Her parents were also unaware, thus, she did not get regular prenatal care.

Case #83 DOD January 2000
Age at death: 16 years
Substance exposed: no
Cause of Death: Dilated cardiomyopathy, obesity
County: Cook
Narrative: Sixteen-year-old boy collapsed while playing basketball at the residential facility where he lived. He was transported to the hospital where he was pronounced dead. The teen came into the custody of DCFS after a June 1999 report of neglect. At that time, the teen was in a psychiatric hospital where he had been for two weeks. His mother had failed to contact the hospital regarding her son. She was located after she herself was admitted to a psychiatric unit

where she signed her son's admission papers by fax. In July 1999, the teen was transferred to another psychiatric hospital and in September he was placed in the residential facility.

Case #84 DOD January 2000
Age at death: 0
Substance exposed: yes, cocaine
Cause of Death: Prematurity
County: Kane
Narrative: Twenty-eight-year-old mother gave birth to her sixth child at 20 weeks gestation. The baby tested positive for cocaine. He lived for one hour after birth. His mother was indicated for death by neglect. The mother has been involved with DCFS since 1991. Four of her six children were born substance exposed. Four children have been adopted. The fifth has been in DCFS custody since his birth. The State is in the process of terminating his parents' rights so he can be adopted.

Case #85 DOD January 2000
Age at death: 2 months
Substance exposed: no
Cause of Death: SIDS
County: Rock Island
Narrative: Two-month-old baby was in bed with his mother. She woke up to find him cold and not breathing. He was taken to the hospital where he was pronounced dead. The family's first contact with DCFS was in June 1996 when the Department received an allegation of inadequate supervision. The mother had left the children home alone and while gone was arrested for a DUI. The case was indicated, but DCFS was not able to make contact with the family until August 1996. At that time, DCFS verified that the mother was in substance abuse treatment and the case was closed. In May 1999, a report to the hotline was indicated for cuts, welts and bruises. The father had hit the nine-year-old son leaving bruises. An intact family case was opened and services were initiated. However, the case was closed because the children appeared fine and the parents were not interested in receiving services. The case was reopened for five months following this child's death.

Case #86 DOD February 2000
Age at death: 3 months
Substance exposed: yes
Cause of Death: Respiratory Syncytial Virus
County: LaSalle
Narrative: Three-month-old baby girl was hospitalized for respiratory syncytial virus for three weeks prior to her death. She died in the hospital. The baby had been placed into foster care following her substance-exposed birth. The baby's twenty-six-year-old mother had earlier been indicated for inadequate supervision of her seven-month-old son who was taken into custody at that time. He is currently in a preadoptive foster home.

Case #87 DOD February 2000
Age at death: four months
Substance exposure: no
Cause of Death: bronchopneumonia
County: Cook
Narrative: Four-month-old baby was found unresponsive in bed with her seventeen-year-old mother at 10:15 a.m. The mother had last seen the child alive when she fed her around 9:00 a.m. The baby was taken to the hospital and pronounced dead.

Approximately one month before the baby died, her mother took her to the doctor for a cold and she was given antibiotics. A week later, the baby was hospitalized for two days with a kidney infection. Two days prior to her death, the mother brought her back to the hospital with the same symptoms. The mother said the hospital took a urine sample and told her to call back in three days. The baby did not have an open case with DCFS, but her mother was a ward of the state. The mother had been in foster care since August 1994 and lived with a relative. She was involved in the Teen Parent Service Network. The deceased was the mother's only child. The teen was emancipated in October 2000.

Case #88 DOD February 2000
Age at death: 12 years
Substance exposed: unknown
Cause of Death: Disease of gastrointestinal system, not otherwise specified
County: Cook
Narrative: Twelve-year-old child and her foster family had attended a church dinner a few days before her death. After the dinner, the child and other family members began to experience stomach problems which they attributed to the dinner. The child did not seem to recover and her foster mother took her to the hospital with diarrhea. She went into shock and was pronounced dead after several hours in the hospital. The thirty-two-year-old mother has had involvement with DCFS since July 1988 when she was indicated for inadequate supervision of the deceased because of substance abuse. The child was removed from her mother's custody and placed in foster care from January 1989 to June 1990. She came back into the custody of the Department in July 1990 after her mother violated an order of protection by leaving the child with someone for two weeks without picking her up. The mother has a chronic substance abuse problem. She has given birth to five children, three of whom tested positive for cocaine at birth. The goal for the children, ages 2, 6, 7, and 10 is adoption.

Case #89 DOD March 2000
Age at death: 2 years
Substance exposed: no
Cause of Death: Pneumonia, hypoxyencephaly
County: Cook
Narrative: Two-year-old medically complex child was brought to the hospital with a fever, tachypna (rapid respiration) and tachycardia. After an hour of advanced cardiac life support, the child was pronounced dead. The child came to the attention of DCFS in February 1998 when a physician reported that the child's mother had not brought him in for his two-week follow-up appointment and when she did, he had lost weight. The medical professionals were concerned he was not being fed properly. An intact family case was opened. In May 1998, the child needed to be readmitted to the hospital and had again lost weight. He was placed in foster care, but eventually was moved to a long-term care facility because of his medical needs.

Case #90 DOD March 2000
Age at death: 2-1/2 years
Substance exposed: no
Cause of Death: myocarditis; bronchopneumonia
County: Cook
Narrative: In March 2000, the child was pulling at her ear so her foster mother took her to the doctor. She was given Tylenol and released. The next day, her foster mother noticed the child was lethargic. She decided to take her back to the doctor. On the way there, the foster parent noticed that the child was not breathing, so she took her to the fire department. The child was rushed to the hospital where she was pronounced dead. The child's biological family has had an

open DCFS case since May 1995. The child came into care in July 1998 when a report was indicated for inadequate supervision after her mother left her home alone. The twenty-eight-year-old mother has a substance abuse problem. All of her children have been adopted except for one child who remains in foster care.

Case #91 DOD April 2000
Age at death: 13 years
Substance exposed: yes
Cause of Death: Congenital abnormalities, cardiomyopathy
County: Cook
Narrative: Thirteen-year-old child was at school. She got up to go towards the teacher and collapsed. The school nurse performed CPR until the paramedics arrived. The child was taken to the hospital where she was pronounced dead. She had been in the custody of DCFS since 1992. She had been the subject of an open intact family case since her birth when she was diagnosed with fetal alcohol syndrome and required several surgeries. Her brother was born positive for cocaine. In 1989, an order of protection was issued. In April 1992, the order was violated and the children were taken into custody. The child was placed in a specialized foster home because of her medical problems. She had a goal of subsidized guardianship at the time of her death.

Case #92 DOD April 2000
Age at death: 2 months
Substance exposed: yes
Cause of Death: SIDS
County: McHenry
Narrative: Two-month-old baby was found unresponsive in the morning by her twenty-one-year-old mother. An autopsy determined the baby died from SIDS. The mother has had an open intact family case since November 1999 when she was indicated for inadequate supervision and substantial risk of physical injury to her one-year-old daughter as a result of substance abuse. The mother was in a substance abuse program, but continued to test positive for cocaine while pregnant. The mother lives with her parents and her surviving child.

Case #93 DOD April 2000
Age at death: 1 year
Substance exposed: no
Cause of Death: Gangliosidosis Syndrome
County: Montgomery
Narrative: One-year-old child was diagnosed with generalized Gangliosidosis Syndrome, a genetic terminal disease that prevented the child's body from breaking down specific enzymes. Eventually, all of her major organs deteriorated and shut down. The child had a life expectancy of 6-8 months. DCFS initially became involved with the child when his mother requested services. The mother was linked with Public Aid, Public Health, and WIC. A second referral for services was received in July 1999 from the Division of Family Services in Missouri, after the child was seen at a hospital in Missouri and the mother reported living in Illinois. The child's mother did not respond to the offer of services. In December 1999, a hospital called DCFS to report medical neglect. The child's mother had missed several medical appointments, the child ended up in the hospital, and the child was ready for discharge, but his mother could not be found. The child was taken into custody by DCFS. The child died at the home of his foster parents. The foster parents allowed the mother to stay with them the last week of the child's life so she could spend as much time as possible with him. His mother and foster parents were with him when he died.

Case #94 DOD April 2000
Age at death: 2 years
Substance exposed: no
Cause of Death: Sepsis
County: Cook
Narrative: Two-year-old girl was brought to the hospital by her foster parent because she was not feeling well. She was pronounced dead that afternoon. The child was at risk for sepsis and infection because of her splenectomy. The child came into the custody of DCFS in November 1999 when she was taken to the hospital after being physically and sexually abused by her mother's boyfriend. Her injuries were so severe that her spleen and pancreas had to be removed. After being released from the hospital, she was placed in foster care. Her mother's boyfriend has been charged with aggravated battery to a child.

Case #95 DOD May 2000
Age at death: 3 weeks
Substance exposed: no
Cause of Death: SIDS
County: Cook
Narrative: Three-week-old baby was found unresponsive in the morning by his maternal grandmother laying face down in his grandparents' king-size bed. A scene investigation showed no evidence of overlay. The infant had been placed in foster care with his maternal grandparents upon his birth. His seven-year-old brother was placed in foster care following the August 1999 death of his six-year-old sister by his twenty-one-year old mother's twenty-year-old boyfriend. The six-year-old's death was the Department's first contact with the family.

Case #96 DOD June 2000
Age at death: 0
Substance exposed: yes, cocaine and marijuana
Cause of Death: Prematurity, maternal drug use
County: Lake
Narrative: Thirty-two-year-old mother gave birth to her fifth child at 21 weeks gestation. The baby lived for five minutes. The mother admitted to using cocaine and marijuana the night before the baby's birth. The mother has not had custody of her oldest three children since 1996. She has not had custody of her youngest since his substance-exposed birth in 1998. The oldest child has a goal of independence, two have goals of adoption, and another is with her biological father.

Case #97 DOD June 2000
Age at death: 3-1/2 years
Substance exposed: no
Cause of Death: Gangliosidosis Syndrome
County: Cook
Narrative: Three-and-a-half-year-old medically complex child was diagnosed with Gangliosidosis Syndrome (also known as Tay Sachs disease), neuromuscular disease, profound retardation, mastocytosis, seizures, cerebral palsy, reflux, and failure to thrive. She was non-ambulatory and blind, and she suffered from muscular atrophy. She was not expected to live past the age of five. The child came into the system at birth because of her complex medical needs. The child was the product of sibling rape.

OIG INITIATIVES

INTACT FAMILY RECOVERY

The Intact Family Recovery (IFR) project was developed in response to OIG investigations that highlighted the tragic consequences of providing too few services to substance affected families. The investigation findings indicated that DCFS generic intact services for families with substance affected infants provided little contact with the families (on average 2 visits per month), workers and supervisors lacked substance abuse knowledge, and there was poor communication and follow through with treatment providers. Further, service provision periods for intact families typically lasted 12 months or less. The poor outcomes of these generic services included cases being closed to the Department without a clear understanding of whether or not the parent had completed substance abuse treatment, as well as births of subsequent substance exposed infants, eventually resulting in placement. These findings prompted an OIG Best Practice Project, the IFR model.

The IFR model integrates a child welfare/substance abuse approach to providing intact family services to families who have delivered a first or second substance exposed infant in an effort to increase child safety and the family's capacity to effectively participate in substance abuse treatment. Basic tenets of the model include immediate and increased communication and collaboration between child welfare and substance abuse treatment workers; comprehensive services offered to the entire family; intensive home visits by both child welfare and substance abuse providers; and cross training in both disciplines. Further, the model implements graduated sanctions in an effort to increase compliance in substance abuse treatment. These graduated sanctions include the use of a Memorandum of Agreement or contract between the workers and parent(s) listing conditions and consequences for noncompliance; prescreening or reviewing the case with the Cook County State's Attorneys Office; and obtaining Orders of Protection mandating treatment compliance. Early data suggests that the use of such sanctions have been effective in compelling parents to complete significant courses of substance abuse treatment. Drug recovery is a long and complicated process. Recognizing this, the Intact Family Recovery program provides services and follows the family for 18 to 24 months.

Through a Request for Proposal (RFP) in 1998, an independent review process conducted by the Department selected three child welfare and three substance abuse treatment agencies from each Cook region to implement the model. Currently, these agencies include Lutheran Social Services of Illinois (LSSI) and Recovery Point serving the South Cook region; Lutheran Children and Family Services of Illinois (LCFS) and Haymarket House; and LSSI and Recovery Point, North.

The following reflects data on families receiving IFR services through June 2000.

General Demographic Information

- Number of participants receiving services = 167
- Mean age of participants = 34
- Mean number of children per family = 3.4

Substance Abuse History

- Primary drug by percent
  - Cocaine 50%
  - Heroin 22%
  - Alcohol 24%
  - Marijuana 10%
  - Other 2%
- Mean years of primary drug use = 9

IFR Substance Abuse Treatment Compliance

- Mothers who have successfully completed one or more treatment levels = 56%
- Mothers who remain in treatment = 8%
- Mothers who entered but did not complete treatment = 23%
- Mothers who never entered treatment = 13%

=100%

Sixty-four percent of the mothers in the IFR program had 90 or more days of substance abuse treatment. Among drug recovery programs, 90 days of treatment is a gold standard. Given the rapid increase in heroin use, more effective treatment interventions for heroin users need to be initiated.

Court Involvement

It appears that graduated sanctions, including court orders of protection mandating treatment, are helpful to families in meeting their duties to their children.

- Total number of court involved families = 63 (38% of the total population)
- Total number of cases resulting in temporary custody = 48 (29% of the total population)
- Rate of temporary custody for cases in which heroin was identified as primary drug = 44%
- Total number of order of protections issued to mandate treatment compliance = 28 (17% of the total population)
  - Of the 28 cases in which an order of protection was issued, 25 (89% of all orders) families entered treatment within 30 days of the order.
  - Of the 28 cases in which an order of protection was issued, 15 (19% of the total population) court order families remained intact.
  - Of the 28 cases in which an order of protection was issued, 13 (8% of the total population) families had temporary custody taken of their children.

Additional Information

- In 61% percent of the families, a father(s) was identified as being involved in their child/ren's life
- There have been 11 subsequent pregnancies (7% of the total population)
  - Number of normal (non SEI) births =4
  - Number of subsequent SEI's = 2
  - Number expecting/other = 5

The OIG will continue gathering data and developing evidenced based practice with this Intact Family Recovery Model.

For the full Intact Family Recovery Report, see Appendix D.

OLDER CAREGIVERS PROJECT

The OIG investigated several cases where children were at risk because of an elderly caregiver's inability to permanently care for the children due to deteriorating ability to maintain alertness, endurance or performing tasks associated with caring for children. In order to properly serve these families, the OIG has developed a pilot project, implementing a revised medical report and bringing administrators together to brainstorm on how to meet the needs of these cases. Details of these four OIG efforts are as follows:

Development of the Problem-Solving Model

A problem-solving model was written in March of 2000 to help staff and the Department's contracted service providers work more effectively with older caregivers. The model was developed by a workgroup established by the Inspector General and the Department after problems identified in a series of OIG investigations. The workgroup reviewed cases where the caregiver was age 65 and older and identified the following concerns impacting the safety and permanency of children24:

- The omission of full and accurate health information of caregivers in court documents
- Failure to incorporate relevant medical information into permanency planning
- Unsafe and inadequate housing and the waiving of foster home licensing standards affecting children's safety
- Absence of back-up care plans involving extended family members
- No evaluation of financial viability
- Exploitation of caregivers by relatives, financial institutions, and, occasionally, adolescents in their care
- Inadequate case planning and follow-up
- Failure to adopt a life span approach as it affects permanency for young children

Each of the above concerns was addressed in the development of the problem-solving model. The model is being tested in the pilot project described below.

Pilot

In July of 2000 the OIG's Best Practice Department launched the Older Caregivers Pilot Project to implement and evaluate the problem-solving model (described above) in the field. The model has three components:

1. Assessment
2. Provision of specialized elder support services
3. Family mediation

A private agency with an elder-abuse and adoption preservation unit is the site of the Pilot. The private agency is following the Pilot Model, providing assessments, specialized geriatric services to identified caregivers and mediation preparation for their families. Law students from Loyola University's Child and Law Center conduct the family mediations. An advisory group consisting of OIG staff, DCFS staff, a geriatric specialist and financial specialist meet regularly to review cases and implement the model.

To date, the private agency has worked with 6 families. The agency has the capacity to serve approximately 24 cases at a time, totaling a minimum of 40 cases in this first fiscal year.

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24 The following list is taken from the executive summary of Older Caregiver/Five Plus Children: A Problem-Solving Model, March 17, 2000 (Revised August 1, 2000).

Medical Report
OIG investigations found elderly foster parents with failing health and degenerative diseases caring for young children. The medical form the Department had been using for the last 20 years was not thorough enough to pick up problems such as Dementia, Strokes, Kidney Disease or any other progressive medical conditions.

The OIG revised the medical form and the changes were adopted into DCFS policy, effective October 1, 2000.25 The revised medical form is to be used by DCFS and private agency staff who arrange for subsidized guardianship and supervise adoptive and foster homes. Foster or adoptive parents' must undergo a medical assessment every four years after licensure. However, if the doctor detects any severe conditions that are progressive in nature, annual reexaminations are required. Finally, due to the added stress the care of other people in the home could place on the caregiver, all adults in the household must undergo a medical evaluation before an adoption or subsidized guardianship arrangement is finalized. This new policy will assist in ensuring the caregivers' capability to care for the child until they are at least age 18.

Brainstorming Meetings
Due to investigations detecting gaps in the foster care system where older caregiver cases were being improperly handled, the OIG hosted a series of brainstorming meetings to bring together administrators from State Central Register (SCR), Adoption, Department of Child Protection (DCP), Child Welfare Services, a private agency, Public Guardian's Office, and the States Attorney's Office. The purpose of the brainstorming meetings was to identify how to properly categorize and provide appropriate services for older caregiver cases that are called into the hotline because the caregiver is unable to care for the children due to their age, mental, or physical conditions. The outcomes of the brainstorming meetings are as follows:

- SCR Trigger Questions - The workgroup decided the older caregiver cases that were called into the hotline were not caught due to the lack of information gathered over the phone by SCR. In order to properly service these cases, SCR must ask questions regarding the caregiver's capability to determine if the case is a dependency case or a neglect case. The group developed questions that would help SCR workers determine the caregiver's mental and physical health to help these cases be properly categorized.
- Dependent Minor Definition - The workgroup also determined that the working application of Dependent Minor did not fully capture older caregiver cases. In response to this, the group decided to expand the application by adding an example of an older caregiver case. This will help the caseworkers begin to think about these situations.
- Compassion Plan – In order to assure that children who are being adopted or have caregivers who are becoming subsidized guardians have lifespan care plans, the workgroup developed a Compassion Plan to ensure a backup person has been properly identified and is involved in the child's life. If anything were to happen that would prohibit the caregiver from caring for the child in the future, the backup caregiver (who will sign the Compassion Plan at the time of adoption or guardianship) will step in as the primary caregiver. This document was developed by the workgroup and is being presented to the Department to incorporate into practice.
- Inadequate Supervision Allegation - The current questions asked in the Inadequate Supervision Category were not thorough enough to catch older caregiver cases. The questions that would help DCP investigators properly assess older caregiver cases determine if they should be referred for specialized services instead of being indicated for

25 DCFS Policy Guide 2000.11. CFS 604, Medical Evaluation of an Adult in a Foster or Adoptive Home.

neglect were not present. To prohibit these cases from being indicated for neglect, the workgroup developed more detailed questions to get a good assessment of the reasoning behind the neglect. These questions will help determine the capability of the caregiver. The changes are being presented to the Department.

For the full report of the Older Caregivers Project, see Appendix C.

INADEQUATE SUPERVISION Recommended Changes
Allegation of Harm #74

B) Caretaker Factors

i) presence or accessibility of caregiver

- How long does it take the caregiver to reach the child?
- Can the caregiver see and hear the child?
- Is the caregiver accessible by telephone?
- Has the child been given phone numbers to call in the event of an emergency?

~~ii)~~ caregiver's ~~age~~ **capability**

- Is the caregiver mature enough to assume responsibility for the situation?
- **Does the caregiver depend on extraordinary assistance to care for self and the child, i.e., meal preparation, laundry, grocery shopping, transportation? Is the caregiver without consistent or reliable assistance?**
- **Is the child assuming primary caregiving duties, i.e., meal preparation, laundry, grocery shopping, transportation?**

iii) caregiver's physical ~~and mental~~ condition

- Is the caregiver physically able to care for the child? **Does the caregiver's own health needs present serious obstacles to the care and well being of the child? (Pay particular attention to the number of children, their ages, and special needs.)**

iv) caregiver's ~~mental~~ **cognitive** and emotional condition

- Is the caregiver able to make appropriate judgments on the child's behalf?
- **Does the caregiver show any sign of confusion or memory loss? For example, can the caregiver give important information clearly and accurately, i.e., child's school, health, date of birth?**

COMPASSION PLAN

A back-up caregiver is someone who has been designated by the guardian or adoptive parent of the child as the person who will act as caregiver of the child when the child's adoptive parent or guardian dies or is unable to make and carry out day-to-day child care decisions concerning the child. By completing this form, the parties are designating a back up caregiver. The parent or guardian and back-up caregiver join together in this plan for the child. The parties understand that signing this form does not change any legal status of an adoptive parent or guardian; the proper legal procedure must still be followed.

1. I, _____, currently residing at _____, am the proposed adoptive parent or legal guardian of the child, _____.

2. I hereby designate _____, currently residing at _____, to be the back-up caregiver for _____, the child listed in Paragraph 1, above.

3. If the person listed in Paragraph 2 cannot or will not act as back-up caregiver, I hereby designate _____, currently residing at _____, to be successor back-up caregiver for _____, the child listed in Paragraph 1, above.

4. We understand that any one or all of us shall notify the Illinois Department of Children and Family Services when the child's adoptive parent or guardian dies or is unable to make and carry out day to day child care decisions concerning the child.

This designation is made this _____day of _____.

_____ _____
Adopting Parent or Guardian Date

_____ _____
Back-up Caregiver Date

_____ _____
Successor Back-up Caregiver Date

_____ _____
Witness Witness

_____
Caseworker

_____
Agency

_____
Address

_____
Date

ETHICS

The OIG Ethics staff pursued several initiatives this year. Volume I of an ethics handbook produced last year was distributed throughout DCFS and private contracting agencies. Volume I was designed to discuss and illustrate the principles contained in the Code of Ethics for Child Welfare Professionals which apply to clinical settings. The Ethics staff also worked with the Child Welfare League of America, which has expressed interest in publishing and distributing Volume I on a nationwide basis. In addition, substantial work took place this year on Volume II of the handbook, in conjunction with Professor Eileen Gambrill of the University of California at Berkeley. This volume is to be entitled *Ethical Child Welfare Practice: A Companion Handbook to the Code of Ethics for Child Welfare Professionals, Volume II: Administrative and Supervisory Issues.*

Members of the Ethics staff presented a workshop at the Child Welfare League of America National Conference in Washington, D.C. in March 2000. The workshop described the development of the child welfare ethics program in Illinois and modeled an ethics training which highlighted some of the major issues in the field, such as conflict of interest and confidentiality.

The OIG continued its partnership with the Park Ridge Center for the Study of Faith, Health and Ethics by holding two forums this year. The first meeting, held in November, brought together professors, ethicists, a judge, and child welfare administrators to discuss conflicting values in child protective investigations and the concept of informed consent as applied to involuntary clients. The second meeting, held in March, dealt with issues relating to professional boundaries and confidentiality. The OIG was honored by the participation of Professor Alan Gewirth, the Edward Carson Waller Distinguished Service Professor of Philosophy of the University of Chicago, who presented a paper on Confidentiality in Child Welfare Practice. Historically, Professor Gewirth's work has provided the foundation for discussion of confidentiality in social work ethics and his paper breaks new ground in applying principles of confidentiality to involuntary clients in the child welfare setting. Material developed at these meetings will also be used to produce scenarios for a training video for child welfare professionals with accompanying instructional manuals.

The Child Welfare Ethics Advisory Board met seven times during the fiscal year. Jimmy Lago, currently Chancellor of the Archdiocese of Chicago, joined the Board. [26] Mr. Lago is the former Executive Director of Catholic Charities of the Archdiocese of Chicago and has participated in several OIG ethics forums. The Ethics Board addressed ethics issues raised by the Inspector General arising out of her investigations and responded to inquiries from child welfare practitioners. Typically, the Board listened to a presentation of a fact situation containing an ethical dilemma, identified the values at stake and the possible conflicts among them, and

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26 As of July 1, 2000, the members of the Child Welfare Ethics Advisory Board were:
Roberta Bartik, J.D., Commander, Youth Investigations Division, Chicago Police department
Michael Bennett, Ph.D., Director, Msgr. John J. Egan Urban Center, DePaul University
Michael Davis, Ph.D., Illinois Institute of Technology's Center for the Study of Ethics in the Professions
Esther Jenkins, Ph.D., Department of Psychology, Chicago State University
Jimmy Lago, MSW, Chancellor, Archdiocese of Chicago
Anthony Marchlewski, M.D., Elgin Mental Health Center
David Ozar, Ph.D., Director, Center for Ethics, Loyola University Chicago
Ada Skyles, Ph.D., J.D., Chapin Hall Center for Children, University of Chicago (Chair)
Eugene Svebakken, MSW, Executive Director & CEO, Lutheran Child & Family Services

recommended possible courses of action to the Inspector General or to the inquiring party. For example, the following issue, which arose in the course of an OIG investigation, was discussed by the Ethics Board in February: A DCFS case manager, Ms. B., who also had a private therapy practice apart from her state job, had been treating a private patient, Ms. M, on and off for eight years for depression, family issues, and emotional issues surrounding her diagnosis with a serious chronic disease. Ms. M.'s four-year old son was then taken into protective custody following an allegation of abuse. Ms. B informed Ms. M that because of their longstanding therapeutic relationship she would continue to counsel Ms. M but could not discuss anything relating to her DCFS involvement because of conflict of interest. As a part of her DCFS service plan, Ms. M. was required to receive counseling about the circumstances surrounding the allegation of abuse with a separate therapist, who had a difficult time getting cooperation from Ms. M. The Ethics Board first agreed that the refusal of Ms. B to counsel about DCFS-related issues was justified to avoid a classic conflict of interest. The Board also noted that the long-term therapeutic relationship between Ms. M. and Ms. B., with its attendant trust, was an important factor to be weighed. On the other hand, Board members questioned whether therapy really could be bifurcated neatly in this way, and whether it would provide effective overall treatment for Ms. M. even if it could be. The Board also raised the concern that in the event that Ms. B. was required to testify in court about Ms. M, an ongoing relationship with her would make it more difficult to determine whether Ms. B. was wearing her therapist hat or her DCFS hat when testifying. There was a difference of opinion among the Board members about whether this situation would create a conflict of interest (i.e. unreliable judgment on Ms. B.'s part) or a conflict of loyalties (i.e. unreliable portrayal of facts) but the Board agreed that Ms. B's proposed solution would not alleviate the problem in the way she had hoped. The harms of continued treatment were seen as outweighing the benefits, and the Board recommended that OIG should advise Ms. B. to discontinue treatment of Ms. M. altogether in order for Ms. M to effectively cooperate and engage in therapy that addressed the child abuse issue.

Other issues considered by the Board included: (1) the inappropriateness of considering a parent's lack of cooperation in the decision whether or not to indicate a case; (2) the factors which should be considered in deciding whether a child's former caseworker may adopt him; (3) the limitations on a DCFS employee advocating within the Department for his stepsons; (4) ethical dimensions of assessing an agency's performance under performance-based contracting; and (5) applicability of the standard on Confidentiality published by the Council On Accreditation of Services for Families and Children to the abuse and neglect context.

The Ethics staff responded to several informal phone inquiries from child welfare professionals, and joined representatives from DCFS's Internal Audits division in forming the DCFS Conflict of Interest Panel which meets weekly to consider secondary employment requests and other conflict of interest questions from DCFS employees.

Pursuant to her role as Ethics Officer for DCFS under the Illinois Governmental Ethics Act, the Inspector General collected and reviewed with the help of the Ethics staff the Statements of Economic Interest from senior DCFS employees and identified problematic gifts or potential conflicts of interest.

CHANCES FOR CHILDREN

The Office of the Inspector General and the Cook County Juvenile Court along with DCFS held *Chances for Children*, a multi-purpose adoption fair, in the spring of 1997 and 1998. *Chances* recruited adoptive families from the general public; provided workshops for prospective adoptive families and licensed families alike; provided pre-application opportunities for families including fingerprinting booths; provided opportunities for families to talk with agency representatives and view listing books; and provided a carnival for waiting children and their foster families. Between 1,000 and 1,200 children, families and volunteers attended each event. The first year, thirty new families were licensed and six known adoption placements resulted from *Chances*. The second year at least 32 children were placed in adoptive homes and over forty families were licensed. Of those 32 children, 15 children were in an adoptive placement with at least one sibling.

Chances for Children was suspended during 1999 and 2000 in order to consider recommendations resulting from the first two years and to create future plans. A private adoption agency took up this task by coordinating a time limited (April 1999 – August 2000) task force made up of representatives from the Department, Juvenile Court, OIG, private agencies and adoptive parents. Six work groups were organized to focus on the identified barriers to adoption that were highlighted in the Inspector General's report, *Chances for Children Transitional Report* (April, 1999). The barriers are: recruitment of adoptive families, adoption events, identifying and matching available children with prospective families, determining the model of a good placement, training and preparing adoptive families and staff development.

Each work group researched their topic, reviewed existing problems and created plans for workable solutions. Recommendations included a coordinated, aggressive approach that will allow every waiting child an equal opportunity for an adoptive placement, early and accurate identification of pre-adoptive foster parents and relatives that might be adoptive resources, accurate identification of children available for adoption, giving all legally free children equal access to all prospective families, providing the best match for the child without agency or caseworker bias, and effective monitoring for timeliness and quality.

The final report from the *Chances for Children* Task Force, (August 10, 2000) is the foundation for future adoption policy decisions for the Department's newly organized Adoption Task Force and the Best Practice unit.

SYSTEMIC RECOMMENDATIONS

SAFETY

- DCFS should not close cases, where there is an indicated finding of abuse, on the basis that the parents or caretakers will not cooperate with services. If the caretakers will not cooperate, DCFS needs to attempt to screen the case into court and continue to try to monitor the safety of the child(ren) while the court petition is being filed. Because of the caretakers' lack of cooperation, such monitoring may include attempts to visit the child in school, day care or other such settings. DCFS should fully document all attempts to contact the caretakers and provide services. If the State's Attorney's Office refuses to file, DCFS should document the reason(s) why and what further information the SAO states is necessary to file a petition.

- As the Inspector General has previously recommended, the LEADS (criminal history background check) protocol and Adult Substance Abuse Screen should be modified. Where drug use is an issue in an investigation, a LEADS check should be required to verify the accuracy of a "No" answer to the items: "Drug or drug-related criminal charges", "Non-drug related charges" and "Have you ever been charged with Driving Under the Influence?"

- DCFS should amend policy and procedure to add a rule stating that the Department must make an independent inquiry of child abuse/neglect indications in other states when an adult member of the household has lived in other states within the last five years. Such an inquiry should be made whenever information is discovered that an adult household member has resided outside Illinois. If the follow-up division finds out such information, the DCP manager should be informed and ensure that such an inquiry is completed. The LEADS protocol currently requires that an out-of-state LEADS check be conducted whenever there is reason to suspect that a subject of a report has a criminal record outside of Illinois. DCP should always make an independent inquiry of CANTS and LEADS in Illinois (even if a certificate, license, or other document is presented that previously required such checks to be completed).

- The Department should adopt the Department Human Services protocol for working with families for whom domestic violence is a factor.

- The Department should perform a database search to identify all cases in which it has guardianship but the child is maintained at home. Each case should be reviewed to determine whether guardianship should continue and whether the child is safe at home.

CHILD ABUSE AND NEGLECT INVESTIGTIONS

- In abuse and neglect investigations in which there is credible evidence of abuse or neglect, but the perpetrator cannot be identified, the investigation must be indicated for abuse or neglect by an unknown perpetrator. The Department needs to communicate to the Hearings Unit and legal staff that when the perpetrator cannot be identified, the report should not be expunged but indicated to an unknown perpetrator.

- The Department must amend its Rules and Procedures that conflict with the statutory requirement to retain certain unfounded allegations for three years.

- The Procedure regarding school employee investigations should be amended immediately to conform to the language of the corresponding Rule.

- The Department should provide training to each of its Child Protective Investigators concerning how to conduct investigations of school employees. Until such training is completed, the Department should ensure that all investigations of school employees are conducted by individuals familiar with the Rules and Procedures regarding investigations of school employees.

- The Department should instruct the State Central Register (SCR) to properly record the date on which the State Central Register receives indicated findings. In the case of a school employee investigation, the date of the indicated finding should match the date on which the notices to the school district were mailed. The Department must also instruct SCR to notify the subject of an investigation about whether a report has been indicated or unfounded on a timely basis.

- The Project Manager of the DCFS database should ensure that 1) the notice of pending child protection investigations (CANTS 21) is clarified to state that the DCP investigator must send a copy of the indicated investigation to the assigned caseworkers/case managers of the other wards in the foster home or relative home placement; and 2) problems regarding transmittal of the notices are addressed.

- The article "PCP Pharmacology: An Overview" 1998, prepared in conjunction with the OIG's investigation of two previous investigations should be distributed to all child protection investigators and incorporated into the curriculum for training of child protection investigators. An understanding by investigators of the dangers of PCP is critical to the assessment of safety and risk of children. (As late as April 2000, a DCP investigator reported he had not seen the article on PCP.)

LICENSING

- Licensing Procedures should be amended to clarify that after an unfounded or indicated finding that does not serve as a bar to licensure, licensing must complete its investigation. The investigation should determine whether 1) the facts support a licensing violation, or 2) there remains a reasonable possibility of abuse or neglect suggesting the need for additional safety measures.

- When foster families transfer their licenses, the receiving agency or DCFS must discuss the reason for the transfer request with both the family and the former supervising agency. The discussion should be recorded in the licensing file.

- The Appeals Unit must refer any expunged investigation of abuse or neglect in a foster or daycare home back to the Licensing Division for a licensing investigation. This investigation may need to be limited to a determination of the need for additional safety measures where there remains a reasonable possibility of abuse or neglect. A copy of the unfounded DCP investigation or the indicated report that has been reversed must be forwarded to the licensing representative. The licensing representative may want to consult with the Guardian ad Litem and, in appropriate cases, with the Medical Director of the Department. If necessary, the licensing representative shall put in place reasonable protective measures and/or restrictions for the home. These could include placing a homemaker in the home, extra monitoring, and restricting the number and the ages of the children in the home. These restrictions must be noted in the licensing file and given to the Placement Clearance Desk. Placement Clearance Desk staff shall place this information in the data system and provide such information to the workers when they call to obtain clearance for their placement.

- Presently, DCFS Rule 383.7 provides that a licensing investigation shall not be conducted when the "alleged violation occurred more than 60 days before receipt of the complaint..." The Department must amend this rule so that a licensing investigation can be conducted upon the completion of an unfounded report of abuse or neglect or the reversal of an indicated report of abuse or neglect. The licensing investigation may need to be limited to the issue of additional safety measures in the foster home or daycare facility.

- Distribute policy and develop training for private agencies and Central Licensing reiterating the need for thorough factual investigations, whenever possible, and the need for corrective action plans that are capable of being monitored. Licensing workers must be required to share information with caseworkers that may be relevant. Specific guidelines defining relevancy should be included.

- All agencies that have received cases from closed agencies must review their licensing files to determine if the appropriate documentation required for licensure is contained in the file. This documentation should include the following:
    - a new application;
    - family home information sheet;
    - copy of the Individual Licensing Summary (ILS);
    - medical report;
    - evidence that a new site visit has occurred and that the home is still in compliance – 590-document compliance record;
    - references; and
    - certificate of foster parent training. LEADS and CANTS information should have already have been verified by the Licensing Department.

  In the event any of this information is not contained in the licensing file, the agency shall ensure that it is completed within 60 days. If there is no medical report in the file and the foster parent is unable to verify the necessary medical information, the Department shall pay for a new one. If there is no certificate of foster parent training, the agency may be able to verify that the foster parent has completed the required training by contacting the DCFS Office of Employee Instruction (formerly Child Welfare Training Institute). The DCFS Licensing Department should monitor this process.

INTACT FAMILY SERVICES

- The Division of Child Protection's Intact Family Service program should develop criteria for assessing the families that are appropriate for its services. Strict guidelines need to be put in place that would prevent a family being considered for the Intact Family Services program when there are severe mental health problems, addiction, domestic violence, sexual abuse, and criminality in addition to child welfare issues.

- The OIG reiterates a recommendation made in May 1998, that the Department more clearly define criteria for cases that are appropriate for Family First or Intensive Family Preservation Services (IFPS). The screening criteria for all Intensive Family Preservation Services programs should be refined to ensure that only cases in which the following two questions can be answered in the affirmative would be accepted:
    - Is the identified problem(s) likely to be corrected (or assessed) within 28 days?

- Can the safety of the child(ren) be reasonably assured during the 28 days?

Protective measures that could be taken to "reasonably assure" the safety of the children during the 28 days should be specified. These should include protective day care and extended family protective caretaking plans.

- The Department should explore the feasibility of developing a program that will provide full intact family services to non-custodial fathers who are not indicated for abuse or neglect and who express an interest in caring for their child(ren). This special intact family program could partner with the Paternal Involvement Project that currently provides adjunct services to fathers who want to be more involved in their children's lives. The Paternal Involvement Project (PIP) offers fathers education, parenting classes, job training and placement, help in establishing paternity, and support groups. In addition to services already offered to intact families, this specialized program should:
  - Establish a care plan for the child(ren), including day care, if needed;
  - Design a visitation plan for the mother; and
  - Ensure that both maternal and paternal relatives are included in permanency planning, if appropriate.

SERVICES (General)

- The OIG previously recommended that the Mentor program be strengthened and expanded and that the Department provide annual ongoing training for mentor parents. The OIG specifically recommends that training for the DCFS mentor consultants and mentor parents include (but not be limited to) behavior management techniques, fetal alcohol syndrome, ADHD, and the use and purpose of psychotropic medication. Also, the Department should clearly define the role of the Mentor consultant and the relationship with caseworkers as well as ensure Mentor consultants are skilled in problem solving, service linkage and coordination and understand adolescence, behavior problems, and mental health issues.

- Investigators should have parents sign consents for release of medical and school information that will be valid for at least six months. Consents should be to DCFS and contracting agencies. The OIG recommends that the Consent For Release of Information, previously submitted to the Department as a recommendation from the Mental Health Confidentiality Task Force, be adopted for use by all DCP investigators, intact, and follow-up workers.

- The Department should focus its efforts on addressing service issues identified by the Quality Assurance Review. When Quality Assurance identifies serious deficiencies then Quality Assurance has an obligation to ensure that remedies have been implemented. Subsequent to Quality Assurance reviews, supervisors should document that they reviewed the findings with the supervisee and that issues were addressed. Likewise, managers should document measures taken to address team related deficiencies.

- The Department should fund multi-systemic therapy services for wards in foster care who have multiple delinquent petitions either pending or adjudicated. This comprehensive, holistic service model should be true to the integrity of the evidence-based research. In addition to foster care, these services should be available to biological families when reunification could be viable with this service.

- Implement expansion of the Child and Youth Centered Information System (CYCIS)/SACWIS tracking system to include a treatment history screen. Psychological treatment and counseling are among the most vital services the Department provides to wards, however current practices make it difficult for workers to construct an accurate perspective of a child's treatment history. Integrating pertinent information into the system would allow workers to develop an awareness of past treatment and monitor further care.

- The Department should conduct an objective analysis for youth with major aggressive behaviors and/or undersocialized behaviors. This analysis should include a description and history of the presenting problem behaviors (including cycles, frequency, rate, duration and intensity), as well as identifying conditions that precede the behaviors (specific times and events), consequences (reactions/effects that might maintain behavior) an analysis of the meaning (functions served by the behaviors) and review of medications in relationship to behaviors. Undersocialized youth should be assessed for functional life skills. A plan should be implemented for all youth who exhibit aggressive behaviors to protect the youth as well as the community.

SERVICES FOR DEVELOPMENTALLY DISABLED WARDS

- Occupational therapy and other activities such as enrollment in an after school or recreational program with children and adults with disabilities, summer camp that serves children with disabilities, should be immediately advocated. If occupational therapy services are not covered by Medicaid at this time, the Department should arrange for reimbursement of services.

- The Department should collaborate with agencies that serve persons with disabilities for training purposes and to develop a user-friendly assessment tool for determining accommodation requirements of a foster home and foster parent in relation to the needs of the foster child with disabilities. Periodic use of an assessment tool would be useful during the child's growth and development to capture changing needs.

TEEN PARENTS

- Issue a directive to the Teen Parent Service Network to refer those pregnant and parenting wards with a history of major psychiatric or emotional problems that reside in home of relative foster care or traditional independent living programs to the Teen Parenting Assessment Team. Once an adequate baseline on the problems of these special need teen parents is developed a more comprehensive service delivery system can be initiated and monitored.

- The Teen Parent Service Network should incorporate a family systems approach, which emphasizes communication and interpersonal processes within the family structure with pregnant and parenting teens and their extended families.

- Teen Parent Service Network should expand their data system to include critical information for tracking purposes. Issues like substance abuse, mental health, mental retardation, violence, should be included in this comprehensive database system.

- When a teen parent, whose family's case is being screened into court, has demonstrated inappropriate and lax parental behavior with their own child that rises to the level of risk to the child, DCP should also screen the child's case into court and request an order of

protection. The order of protection will provide a measure of safety for the child and some structure for the teen parent.

OLDER CAREGIVERS

- The possibility of removing children from 'grandparents' with whom they are closely bonded calls for special supervisory advice for the workers. The Department should develop an independent relationship with a gerontologist to be available to workers. Workers and their supervisors must pay attention to these cases involving older caregivers in order to arrange for consults.

- Private agencies should establish independent teams to review their foster care and home of relative cases involving older caregivers who are being prepared for adoption and subsidized guardianship. The OIG will provide the agencies with the report on the Older Caregiver service model.

DEPENDENCY

- The Department should reconsider prior OIG recommendations pertaining to the development of a dependency allegation category and handling of dependency reports by SCR and child protection investigators. The Department must ensure that SCR staff is properly trained to appropriately handle dependency related allegations. The Department's established procedures for referring dependency cases to its Child Welfare Services unit, need to be implemented.

SEXUALLY AGGRESSIVE WARDS

- A child who is an alleged perpetrator in an abuse/neglect investigation should not be entered in the Sexually Aggressive Children and Youth (SACY) database until the investigation of the incident in which the child is involved is completed and the allegation against the child is indicated.

- Rather than spending approximately $1.2 million over the next 18 months for the existing contract for tracking or intervention with Sexually Abusive Children and Youth (SACY) wards or training and certifying SACY providers for FY2001, it would be more prudent for the Department to redirect these resources to the DCFS Best Practice Unit of the Clinical Division. The Best Practice Unit must include pediatricians, child psychologists and human development professionals with expertise in child development and aggression behavior management in the training of any DCFS designated screeners and assessors. The training must cover child and adolescent development including sexual development and developmental issues in the foster care population.

- Redirect all Unusual Incident Reports (UIR), questions and concerns regarding a child's serious aggressive behavior to the DCFS Best Practice Unit of the Clinical Division and discontinue the SACY database for all children and youth. This unit will develop a screening and assessment referral system to offer assistance to children and families. Further, this unit will develop a triage approach that would immediately refer children with developmental delays or severe learning disabilities to the University of Illinois Department of Disability and Human Development (IDHD) for assessment, and development/implementation of a service plan for the child and caregivers. The Developmental Disabilities Coordinator should be designated to monitor follow-up for children who have developmental disabilities. Children with average cognitive abilities will be referred to a diagnostic center for assessment using the program guidelines

recommended in "Treatment of Children with Sexually Problematic and Aggressive Behavior." (Horton, 1999)

- Whenever possible, home and family-based therapeutic services that include appropriate developmental opportunities for children with behavioral problems, as well as developmental pathways such as leisure and recreational activities must be used for children with sexually aggressive behaviors. Behavioral home-based family intervention is effective in creating more positive outcomes for children in the family and caretakers.

MEDICAL

- The Department should implement the diagnostic network for failure to thrive as well as establish protocols for identifying the physical and behavioral indicators of failure to thrive and Fetal Alcohol Syndrome including the characteristics of FAS over the life span.

- The OIG has arranged for all Healthworks physicians to receive a copy of the OIG's Asthma Report.

- Department personnel, especially caseworkers and nurses, need to be trained to identify primary care physicians who are not following National Heart Blood and Lung Institute (NHBLI) guidelines on diagnosing and treating asthma.

- Division of Child Protection investigators should receive training regarding the necessity of asthma action plans and asthma education in medical neglect charges involving children who have asthma.

- DCFS needs to develop guidelines to implement Rule 325, which governs the administration of psychotropic medications to children for whom the Department is legally responsible.

- DCFS should consider amending the Child's Summary in the Client Service Plan to include more detailed health and medication information. DCFS has inadequate information regarding the behaviors that require medications. The complete records of a child must be reviewed to be able to evaluate a child's medical needs.

- DCFS should consult with the Institute for Juvenile Research at the University of Illinois-Chicago, in developing a protocol regarding the Diagnosis and Treatment of wards with ADHD or ADD.

- Create a database to track all children with serious, long-term, chronic medical conditions and/or children who take psychotropic medication. All children in the database should be assigned to a DCFS nurse who will have responsibility for tracking and follow-up. (See OIG Asthma report, 1999.)

- The Department should prepare a memorandum to be distributed to all child protection workers emphasizing the importance of the immunization rule and the need to enforce it. When parents are unable to provide proof of immunization, investigators should give them thirty days to comply. If investigators do not receive verification of immunizations, the case should be indicated for medical neglect. Investigators can use the attached immunization schedule for verification. Investigators, intact, and follow up workers should be aware of and encouraged to work with their local Departments of Public Health

programs for immunizations. In Chicago, parents can access Department of Public Health Care Vans that travel daily to different sites in the city. In addition, Public Health Nurses may be available to make home visits.

- The Department's Chief of Nursing Services should meet with the supervisors of intact family units to discuss health and compliance issues among intact families. Among the health concerns that should be addressed are asthma management and immunizations. The Commissioner of the Chicago Department of Public Health, and the nurse consultant to the OIG, should be included in this meeting. The OIG recommends that this meeting be hosted by the private agency involved in a case in which immunizations were an issue.

ETHICS

- The Department Rule that addresses Department employee sources of income and conflicts of interest (Rule 437) should be amended to remove the exception allowing DCFS Foster Parent Support Specialists to be licensed for foster care by DCFS. The Rule should not permit any exceptions.

- All private agency and Department employees must be (re-)trained on Rule 437 and conflicts of interest.

- DCFS should notify, in writing, all DCFS field offices and private agencies that Department and Agency employees must not be licensed for foster care by their employer or an entity with which they have a working relationship. All employees currently licensed for foster care by their employer or an agency with which they have a working relationship must transfer their license immediately. The Department should conduct a random audit to verify implementation of this recommendation.

- Workers should be made aware that when they do not agree with their supervisor on a substantive issue with strong ethical implications, they can ask the Office of the Inspector General for an ethical consultation as to how to proceed. All DCFS employees should be encouraged to approach the DCFS Ethics Board when faced with a possible conflict of interest.

- All DCFS contractual employees should sign a Conflict of Interest Statement when signing their contracts. A copy of the Statement must be maintained with the contract. All contracted employees should receive a copy of the Code of Ethics for Child Welfare Professionals.

- With the assistance of the ethics team from the OIG, a private agency whose employee had a romantic relationship with a developmentally delayed adult client should write a new Code of Ethics for its employees. Alternatively, the agency should adopt the Code of Ethics for Child Welfare Professionals in its entirety and make that clear to its employees in the employee handbook that it is currently revising. Its current Code of Ethics is not as strict as the DCFS Code of Ethics, and does not include a definition of conflicts of interest, a discussion of boundaries issues, or a discussion of sexual relationships with clients.

CONFIDENTIALITY

- DCFS should advise supervisors that whenever legitimate casework or clinical concerns dictate sharing information, but it appears that concerns over confidentiality do not allow such sharing, the supervisor must contact DCFS Legal, who will document both the call and the answer given to the supervisor. The OIG will monitor these calls as part of a continuing investigation of casework confidentiality issues.

- The legal parameters of taping meetings and interviews should be incorporated into DCFS Legal Services' training on confidentiality.

COLLABORATION WITH OTHER DEPARTMENTS

- The Department should work with the Illinois Department of Education and the Illinois Department of Public Health to have indicated abuse or neglect that was reported by school faculty or staff noted on a student's permanent health record that transfers with other school records when a child changes schools. This will inform the new school that the child has been a victim of abuse or neglect in the past and the staff, as mandated reporters, should be attentive to signs of abuse or neglect and excessive absences.

- The Illinois Department of Public Health (IDPH) should revise its certificate to clarify that it is not intended as a substitute for criminal or abuse and neglect background checks.

PERSONNEL

- The OIG should meet with Human Resources staff of a private agency who hired a child welfare worker who had had a romantic relationship with a developmentally delayed adult client while employed with another private agency to discuss their hiring practices and policies. The agency must check references and employment to ensure that applicants that are not qualified are not hired to provide child welfare services.

- Supervisors should be instructed that when they see blatant violations of professional boundaries, they should remove workers from a particular case immediately.

- Agency Performance Teams (APT) should keep all private agency records, including personnel records, after an agency closes.

- The Department's records show an increase in the number of child abuse and neglect calls from the Central region. The Department needs to examine the population growth in the area and consider increasing child welfare staff to meet projected need.

- Implement policy and train administrators on how to respond to *suspected* contractual and employee drug and alcohol abuse. The policy should address confidentiality, and appropriate supervisory procedure, response and documentation. The procedures should also address what signs to look for regarding drug and alcohol abuse.

- The Department should conduct abuse/neglect and criminal background checks (CANTS and LEADS) on temporary employees before employment begins. Temporary employees should also be required to sign a statement that any abuse of state property or forms will subject them to immediate termination of their assignment and notification to the agency that placed them.

- Notify private agencies that subcontractors and volunteers who have contact with wards must be cleared by abuse/neglect and criminal background checks (CANTS and LEADS).

- Establish a procedure whereby equipment purchased for employees as accommodations follow those employees when their jobs or work locations change.

- Revise DCFS policy to prohibit retaliation against employees or others who oppose that which they reasonably and in good faith believe to be either unlawful discrimination, or other conduct which violates laws or DCFS policy; as well as retaliation against employees or others who have made an internal or external complaint, testified, assisted, or participated in an investigation, proceeding, or hearing; and to prohibit willful interference with investigations of such conduct by employees or designees of DCFS.

- Revise DCFS policy to provide for those benefits of the Family Medical Leave Act (FMLA) which are not offered by either the current Family and Responsibility Leave, or Disability, policies of the agency, with the review and approval of Central Management Services (CMS); at a minimum, such revisions would allow intermittent leave on a planned or unanticipated basis for those with chronic conditions who have appropriate advance certification by a physician, for therapy, appointments with a medical provider, or time off due to temporary incapacitation.

- Develop policy that would require employees to submit periodic (at least yearly) medical documentation as to whether a condition once characterized as chronic in fact continues to require the same type of accommodation, including, where applicable, intermittent leave.

- Cause an internal audit of personnel and labor relations files, and job descriptions, for compliance with Central Management Services (CMS) and Personnel rules, and sound human resources practices, by someone outside the Office of Employee Support (OES).

- Direct the Affirmative Action Office to seek a sign-off from the general counsel's office of its final reports involving alleged sexual harassment by a manager, for compliance with applicable laws, and accuracy of its fact-finding summaries.

- Direct Affirmative Action Office and management staff involved in investigations to honor confidentiality commitments that internal investigators may use in order to obtain information, until and unless use of such information is necessary to fully interview person(s) accused of wrongdoing, or to impose any discipline.

- When a unit being investigated by the Affirmative Action Office reports to the same person as the Affirmative Action Office, provide an alternative person to do the investigation to avoid a conflict of interest.

- Revise DCFS policy on sexual harassment to reflect an intent to comply with the most strict of the various statutory prohibitions that apply to DCFS, and for accuracy on current federal law.

- Revise DCFS policy to prohibit retaliation against employees or others who oppose that which they reasonably and in good faith believe to be either unlawful discrimination, or other conduct which violates laws or DCFS policy; as well as retaliation against

employees or others who have made an internal or external complaint, testified, assisted, or participated in an investigation, proceeding, or hearing; and to prohibit willful interference with investigations of such conduct by employees or designees of DCFS.

- Maintain Office of Employee Support employee's job descriptions on the same basis as those of other employees, and decide salary adjustments on the same basis as other employees.

DISCIPLINE

The OIG recommended that DCFS or private agency staff be disciplined for the following misconduct:

- A DCP investigator was the subject of a complaint regarding unprofessional behavior. During the course of investigating the allegation, the OIG found that the investigator had been convicted of Aggravated Assault in 1992 while he was employed as a probation officer. The investigator had gone into the field with an intern and at some point held a loaded gun to the intern's head and threatened him. The investigator was suspended pending disciplinary action but resigned before the matter was resolved. The Aggravated Assault conviction was later expunged from his record. When the investigator applied for the position with DCP, he answered "no" to the question regarding whether he had ever been convicted of a felony. The OIG contacted the Department's Labor Relations office and provided them with all the information and documents that had been obtained. An outside legal consultant advised the Department it could not discipline the investigator on these facts and the investigator remained with the Department, where he was heard to state that he would kill his supervisor and feed her to the alligators. The Department attempted to discharge him based on the threat, but an arbitrator reinstated.

- Failing to conduct background checks on relative foster parents, facilitate parent/child visitation, respond to the natural mother's concerns about the safety of her children in the relative foster homes, refer the natural mother for counseling services in a timely manner, refer children to necessary counseling, keep adequate records, or monitor the foster homes. In addition, the OIG learned that the employee had falsified his employment application.

- Failing to make any collateral contacts and interview all members of the household in a child abuse and neglect investigation in a case where the child was subsequently killed by the mother's boyfriend.

- Closing an intact family services case based upon the parents' non-cooperation rather than an alleviation of risk factors in a case where the child was subsequently killed.

- Signing off as a supervisor on an inadequate child abuse and neglect investigation in a case where the child was subsequently killed.

- Failing, following the completion of a child abuse and neglect investigation of injuries to an infant, to proactively respond to the grandmother's reports of observing bruises on the infant in a case in which the infant was subsequently killed by the father.

- Failing to complete annual compliance forms and failure to formally document contacts with foster parents, substitute caretaker background checks, and licensing investigations.

- Failing to conduct a proper initial child abuse and neglect investigation and failing to adequately assess the potential risks to this child and failing to adequately and accurately document investigative steps.

- Failing to comply with the criminal history background check protocol.

- Failing to adequately supervise a follow-up worker and failing to identify and utilize resources available to a family.

- Failing to provide adequate case management services.

- Failing, as a supervisor, to review the child abuse and neglect investigative file properly and failing to recognize that the investigator did not comply with the Department Rule on conducting abuse and neglect investigations involving school personnel.

- Engaging in a sexual relationship with a past client; engaging in a sexual relationship with the mother when she was a current client; interfering with the mother's visits with her children; failing to recognize boundaries; failing to accurately note his whereabouts and visiting his paramour at her home during work hours without notifying his supervisor; having a history of court no-shows; having the court make a finding that he made no reasonable efforts in the mother's case; making misrepresentations in court.

- Failing to supervise an appropriate assessment and the delivery of comprehensive case management, failing to recognize the necessity of calling the State Central Register (SCR) and failing to call SCR in an intact case in which an infant was killed.

- Failing, as a therapist, to recognize the necessity of calling SCR and failing to call SCR in an intact case in which an infant was subsequently killed.

- Failing to critically evaluate the foster parents and the Local Area Network (LAN) recruiter during the foster home licensing process, failing to enforce corrective action plans, and failing to conduct adequate licensing investigations.

- Failing, as a child abuse and neglect investigator, to follow basic investigative procedures, assess risk to children, and follow supervisory direction in at least three child abuse and neglect investigations.

- Signing the name of a caseworker on a case transfer form without permission and against Department procedure.

- Failing to appropriately notify the adoptive mother's supervisor and the private agency of the mother's DUI, driving restriction, and apparent drinking problem, and failing to provide guidance or otherwise address suspicions of alcohol abuse.

- Failing to adequately assess and investigate the allegations of corporal punishment against the 11 year-old and the other children in the home.

- Failing to conduct basic child abuse and neglect investigative procedures and follow supervisory direction from both a supervisor and the clinical consultant/field teacher.

- Failing to adequately supervise child abuse and neglect investigations and failing to ensure that investigators under her supervision understand and carry out instructions.

- Failing to ensure that the Substance Abuse Screen was complete and sent to the provider; that the internal notices of investigation (CANTS 21) had been sent to the appropriate staff and that a copy of the DCP file had been sent to the appropriate staff.

- Failing to interview the alleged perpetrator in a child abuse and neglect investigation.

- Failing, as a supervisor, to conduct proper reviews of case notes and improperly delegating child abuse and neglect investigations.

- Permitting, as a supervisor, the illegal taping of a meeting for which he was responsible.

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Office of the Inspector General

REDACTED REPORT

This report is being released by the OIG for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names are fictitious.

File No: 972925
Minors: Timothy Clarke (DOB 8/23/91, DOD 9/26/99)
Subject: Death of Timothy Clarke

Summary of Complaint

In September 1999, eight year-old Timothy Clarke was allegedly killed by his mother's live-in boyfriend, Charles Kemper. Kemper allegedly murdered Timothy by beating him over the course of three weeks. Timothy's mother, Shelly Clarke, was in Arizona at the time of his death, but was thought to have knowledge of the ongoing abuse that led to his death. Both have been charged with first-degree murder.

The State Central Register ("SCR") informed the Office of the Inspector General of the death of Timothy Clarke as a B sequence report (second report).[1] SCR also referred the report to the Division of Child Protection ("DCP") for investigation. The Department of Children and Family Services ("DCFS") previously indicated Timothy's caretakers for cuts, welts and bruises on Timothy in May 1999. Shortly after that investigation began, DCP referred the family to the follow up division for assessment and services. The case was closed in June 1999, when the parents were not interested in services. It was later discovered that Kemper had previous indicated abuse reports in the state of Arizona.

Summary of Investigation

Sequence A Investigation

DCFS first became involved with Timothy Clarke in May 1999. On May 10, 1999, about 12:48 p.m., a faculty member from Maxwell School in Allerton made a report to SCR that Timothy had fresh bruises and welts on his back. The reporter stated that when Timothy was asked about the injuries he said, "if you tell, I'll get in trouble again." The faculty member said that Timothy feared further abuse. The reporter stated

[1]The Office of the Inspector General is notified of all deaths of children whose families have been involved with or investigated by DCFS within a year prior to their death.

that according to Timothy, Charles Kemper, his mother's live-in boyfriend, caused the injuries. SCR took a report for investigation of allegation 11, cuts, welts and bruises.

Child Protective Investigator ("CPI"), Joel Nesmith, from the Division of Child Protection ("DCP"), was assigned the investigation and called Maxwell School about 2:30 p.m. Nesmith spoke with a staff member at Maxwell school who informed him that Timothy was registered with an Allerton address, though the address given to SCR was a Griffin address. The staff member told Nesmith that Timothy was in third grade and had transferred there from Arizona. Nesmith next spoke to the reporter. The faculty member reported that Timothy was in the classroom next to her. Timothy's teacher was too distraught to talk so she made the report. The reporter said she did not know where Timothy and his family lived, just that it was in Griffin and Timothy was finishing the year at Maxwell school. Upon learning about the address discrepancies, Nesmith called Deputy Michelle Getty through 911 to check the Griffin address. Nesmith found the address was listed to Laura Harmon. Nesmith then phoned the manager of the Griffin apartment complex who confirmed that the apartment was rented to Laura Harmon, but believed that other people had moved in with her.

By 3:10 p.m. Nesmith had gone to the apartment and spoken with Shelly Clarke, who answered the door. Nesmith told OIG staff that initially Clarke told him, "Shelly isn't here," but she soon admitted she was Shelly Clarke after he introduced himself. Nesmith explained the reason for his presence and asked her how Timothy got the marks. Clarke replied that Timothy had been spanked the previous day. She said that Kemper spanked Timothy and she had talked to him about it. Clarke said that Timothy had been lying and stealing and those were the reasons he was spanked. She believed that Kemper used a belt to spank Timothy, but it could have been an extension cord. Clarke told Nesmith that she would not punish Timothy because he told someone about the marks and that nothing like that incident would happen again. The CPI told OIG staff that it was clear that lying was a big problem for Kemper, but Clarke felt that the whipping was too much and she and Kemper agreed that Timothy would not be punished in that manner again. Clarke went on to explain that they had recently moved to the Allerton area from Serazen, Arizona. Her parents lived in Mayfield and she had grown up there.

Kemper was out with Timothy but Clarke expected them back at any minute. Nesmith explained that he would wait for them and he would need to talk to Timothy alone. Nesmith then observed two week old Shannon who was asleep in her crib. Nesmith wrote that she appeared to be a typical two week old, and that she had been in the hospital because she was born with pneumonia. Kemper called the house at 3:35 p.m. The CPI spoke to Kemper who said that he had taken Timothy to Griffin for ice cream and they would be home shortly.

After Kemper and Timothy returned home, about 3:40 p.m., the CPI spoke with Timothy. Nesmith told OIG staff that he spoke with Timothy alone, away from Kemper and Clarke. Timothy told the CPI the following (as recorded in Nesmith's investigative notes):

-said he was doing fine
-he got a spanking with an extension cord because he lied
-he doesn't get whipped a lot, just whipped once in awhile, usually with an extension cord
-he got whipped yesterday.

Nesmith told OIG staff that he asked Timothy what he lied about and Timothy said it was about homework, but he could not remember specifics. Nesmith said he watched for any hesitation by Timothy, especially because of the fear of repercussion mentioned in the CANTS 1 and because Kemper and Timothy had the ride back from Griffin to talk. Nesmith stated that he did not see or hear any hesitation or any sense of holding back. Nesmith also examined Timothy for bruises and marks and completed a body chart. On the Suspected Abuse Injury Notesheet, Nesmith documented extension cord marks fully covering the buttocks,

some marks on Timothy's lower back and some marks on his upper thighs. He also documented a mark near Timothy's left shoulder blade that he wrote occurred when Timothy had fallen on the road. Clarke was present for the body examination as dictated by policy.

The CPI then spoke with Charles Kemper. His investigative note reflected that he spoke with Kemper alone. Nesmith told OIG staff that Kemper admitted that he whipped Timothy too hard. Kemper stated that he had whipped Timothy because Timothy lied and knew better. Kemper admitted to whipping Timothy's buttocks and to causing marks on his legs, but stated the whipping was a last resort. Nesmith documented that he informed Kemper that the whipping constituted abuse, not simply punishment. Kemper answered that he did not do anything to Timothy in anger; he spanked Timothy with a cord while he was in his underwear only out of caring. He told the CPI that he would not spank Timothy again with an instrument and that Timothy would not be punished for telling someone about his bruises and causing DCFS to investigate.

In an interview with OIG staff, the CPI added some details and observations. Nesmith said that he considered his discussions with Clarke and Kemper as a "very good and appropriate exchange." He found them to be cooperative, not defensive or causing an altercation. In looking at the marks on Timothy, the CPI noted there was bruising mainly on the buttocks with some marks on the meaty part of his legs. The marks were not cuts or open wounds, which the CPI said would have been more serious, but bruises which were typical from being whipped with a cord. The CPI noted that both Clarke and Kemper had educations. Clarke said she was an LPN (Licensed Practical Nurse), though not yet licensed in Illinois, and Kemper was a CNA (Certified Nursing Assistant). Kemper was registered in Illinois and showed Nesmith his Registration Verification letter issued by the Illinois Department of Public Health. Nesmith said that the 1999 certificate listed child abuse/neglect charges as zero. Kemper told the CPI that he had a job and would be starting soon. Nesmith stated he did not do a safety plan because he did not feel it was necessary. Rather, he had the parents sign an agreement stating they would no longer use whippings to discipline Timothy. Nesmith said that there was "nothing to indicate that this child was in imminent danger." Nesmith discussed with Clarke whether there would be repercussions for Timothy and Clarke assured him that Timothy would not be punished. Nesmith said that he was aware of the fact that the family came from Arizona. They told him they moved to Illinois looking for better employment. Nesmith believed that Kemper stated they had no prior child protection involvement, so he did not consider calling Arizona at the time. Since Clarke, Kemper, Timothy and Shannon were living in a small apartment with friends, Nesmith mentioned to them that DCFS might be able to assist them with housing through Norman money and their reaction was very positive.

Nesmith called Clarke the next day, May 11, 1999. Clarke said that everything was going well. Timothy had lied again last evening and she was having trouble understanding why Timothy would lie about something as trivial as having no homework, as he was getting straight A's in school. Clarke said she planned to return to work in about four weeks, but that she wanted first to spend some time with Shannon. Nesmith again offered services. Clarke said they would think about it, but they would likely accept services and possibly Norman funds as they currently had no place to live.

Enhancement Services

After gathering enough evidence to indicate the case, Nesmith made a referral to follow up for services and began the process for Norman funding. On May 12, 1999, Nesmith called an agency to refer Clarke for a housing advocate to assist in locating appropriate housing for the family. He reported that they had no known back debt for utilities or rent. Kemper was reportedly working as a CNA and Shelly was currently not working because of Shannon's recent birth. Nesmith informed Clarke that Jill Carter would be their housing advocate and would contact them later that day. Nesmith spoke with Carter who confirmed that she was on her way to meet the family.

Nesmith contacted the follow-up worker, Marlon Bell, on May 18, 1999. Bell was assigned to do a thirty day assessment on the family in order to decide if a case should be opened. Bell informed Nesmith that the housing advocate had given Clarke and Kemper some listings for them to check. They believed they could afford a place for $300-$400 a month. Bell attempted a visit the previous day but Clarke and Kemper were not home. He had an appointment scheduled for May 19, 1999, at 10:00 a.m.

Nesmith attempted to contact Timothy's teacher, Ms. Koch, on May 18, 1999. He spoke with her the following day. Ms. Koch said that Timothy had complained of back-itching the day the report was made, and she asked Timothy if she could see his back. She saw the marks and realized that he had been whipped. Timothy was hesitant to report what happened; he was afraid that if he told it would be worse for him. Instead, Timothy nodded when asked if his dad had done this to him. Ms. Koch related that since the report was made, Timothy was happy and more attentive to the teacher. She said Timothy always seemed happy and one would not have suspected any abuse. Nesmith did not ask Ms. Koch about Timothy lying or being non-compliant with homework. Nesmith then spoke with Ms. Philpotts, the reporter, to inform her he was going to recommend the case be indicated. Ms. Philpotts mentioned that she noticed Timothy was doing well since the report.

On May 21, 1999, Nesmith spoke with the housing advocate. Carter said she had not seen the family that week. She was told by Bell that he would call her after the visit. Also, Clarke and Kemper were looking for housing on their own and were to contact Carter if they found something. She planned to check with the couple the next week. Four days later Nesmith spoke with Clarke who said that they had found a place to live at Corning, about forty-five minutes from work, but Bell had reservations about them being able to afford the residence. Kemper was making $8.00 per hour and Clarke planned to renew her LPN license. Nesmith indicated that he would talk to Bell. Bell spoke with Nesmith and confirmed that the family had found a place, that the rent was $400 and the deposit was $350. Ms. Carter told him that she felt it was a good residence for the family. Bell spoke with his supervisor, Deena Rodman, who had concern over the amount of rent and the distance to work. The following day Nesmith wrote that he again spoke with Clarke who said the housing advocate had told her that the funds for the Corning residence were going to be approved. On May 28, 1999, Bell informed Nesmith that his supervisor, Deena Rodman, determined that the income the couple was receiving would not be sufficient to support the residence at Corning.

That same day Bell informed Clarke and Kemper that the Norman funding for the apartment was not approved since their income was projective figures-not actual income and there were concerns about their ability to sustain the rent. Clarke and Kemper replied that DCFS had lied to them, they did not want services and hung up the phone. On June 1, 1999, Bell called public aid and confirmed the income Clarke was receiving ($349 TANF, $329 Food Stamps). Later he attempted a home visit to discuss other options, no one was home. A second visit was attempted on June 4, 1999. Clarke and Kemper were not home, but Timothy was there with Laura Harmon. Timothy was eating at a table. He spoke to Bell, but the specifics of the conversation were not noted. Bell attempted three more visits to the Harmon residence on June 8, June 9 and June 11, 1999. At the last two visits Harmon told Bell that Clarke and Kemper still lived there. After the last visit Bell contacted Nesmith and said he believed the family was gone. Bell told Nesmith that he passed the residence everyday and had not seen Clarke's car.

DCP's next activity in the case came on June 16, 1999, after being contacted by the follow up division. CPI Ramona Pender visited the Harmon residence where the family had been staying. No one was home so Pender left her card for the family to call DCFS. Less than an hour later Pender received a call from Laura Harmon who had returned home and found the card. Harmon stated that Clarke, Kemper and the children moved to the Corning area several days previously. Harmon did not have an address, or a phone number. Bell also visited and had left a message with her for Clarke to call him. Harmon said she relayed that message to Clarke. Harmon also stated that Kemper had a job at a nursing home in Algona starting Monday making

$10.00 an hour. She stated if Clarke came by she would get their address and call DCFS with the information. Pender paged housing advocate Carter, called SCR to do a soundex on Charles and Shannon Kemper and attempted to call Ms. Philpotts to inform her that the case would be indicated. Maxwell School informed her that Ms. Philpotts was on vacation. Pender said a letter informing her of the indicated finding would be sent to the school. Carter returned the call on June 17, 1999, to inform Pender of Clarke and Kemper's new address.

Nesmith attempted to visit the family at their new home on June 17, 1999. There was no answer, but he confirmed the residence with a neighbor. The next day, June 18, 1999, Nesmith went to the home again. The CANTS 17A reflected that all family members were home. The environment looked good, and they appeared to be doing well. Kemper and Clarke told him they felt good since getting their own place. The parents stated they were upset about the Norman Funds not being made available to them, especially since they were willing to sign an agreement to repay any money if they did not stay at the address for at least a year. They denied any further corporal punishment of Timothy. Nesmith informed them that the report would be indicated, and again offered them services that they refused.

Family Assessment

Nesmith filled out a CFS 1440, Family Assessment Worksheet Factor to complete the investigation. The form asks for an overall risk assessment of the family and specific areas of risk. Nesmith gave an overall risk rating for the family as low risk. In the first specific section, Family Assessment Factors, Nesmith wrote his observations as "Charles (paramour) used excessive corporal punishment (electrical cord) to discipline Timothy. According to Charles and mother, Charles will no longer discipline. Shelly, Charles and children have been living on and off with family and friends, currently with friends. Family needs assistance in establishing a stable residence, they are Norman certified." He wrote that the family's perception of the problem was that Clarke knew excessive corporal punishment was used and that she and Kemper agreed that there would be no further use of corporal punishment. In the Caretaker Assessment Factors sections, which includes caretaker development, emotional health, substance misuse, criminal behavior, parenting skills, interaction and access to child, all factors were rated low or no risk. In the narrative, Nesmith noted that Clarke had recently given birth and Kemper was a C.N.A. with limited income. In the Service Provider Assessment section, Nesmith noted that Clarke and Kemper had been cooperative and agreed that excessive corporal punishment was used.

The Child Assessment Factors section examined the child's age, behavior, and interaction with siblings, peers and caretaker. Nesmith gave an intermediate risk to Timothy because of his age and a high risk to Shannon in the age factor. The other factors were all rated as no risk. Nesmith observed that Timothy was punished for lying and excessive corporal punishment was used, but that Timothy had good school attendance and good grades. He wrote that Shannon had been born with pneumonia but appeared to be developing and recovering well. Nesmith expressed that the family's strength was the realization of the error of the punishment and the acceptance of the housing advocate. A weakness was the parents having to cope with a newborn baby who had been born with pneumonia. The family would be able to remain united as long as they refrain from corporal punishment and obtain suitable housing. The severity of the abuse was rated as intermediate risk, the location of the injury rated as low. The finding was written as #11, cuts, welts and bruises – indicated – "Both mom and Charles agree excessive corporal punishment (electrical cord) was used to discipline Timothy. There was bruising covering the buttocks with lines on the lower back and legs." The allegation for # 77,inadequate shelter, was initially listed as pending and was updated on June 18, 1999, as unfounded since the family had obtained a more adequate residence.

Nesmith completed a Child Endangerment Risk Assessment Protocol ("CERAP") on May 10, 1999. All safety factors were checked "no" except for "Caretaker caused moderate to severe harm or has made a

plausible threat of moderate to severe harm to the child." Nesmith crossed out the word severe and circled moderate. The explanation noted that Kemper whipped Timothy with an extension cord, leaving moderate bruising to the buttocks and legs and stripes on the lower back. Clarke and Kemper signed the CERAP agreeing not to use that type of corporal punishment again. The safety decision was checked safe and no safety plan was specified.

OIG Interview with Maxwell School

The OIG also spoke with Maxwell School Principal, Lee Hriniak, and Maxwell School teachers, Ms. Koch and Ms. Philpotts. Ms. Koch remembered that Timothy had complained one day about his back itching, and she asked if she could see his back. She told the OIG she saw four to six bad marks across his back starting from just below the shoulder blades to his lower back. The wounds were not open wounds but were red, purple, yellow and green. The principal remembered Timothy's mother coming to enroll him in school. Clarke intimated that Timothy might be a problem. Principal Hriniak specifically put Timothy in Ms. Koch's class because she handles children so well. Ms. Koch said Timothy had a little bit of a problem on his first day but after some guidance he did very well and never had a problem again. The faculty did note that Timothy had always worn long shirts and pants, even in the warmer months. The school had some contact with the mother. They recalled her coming to school one day, not finding Timothy immediately and becoming hysterical until Timothy was found. The faculty members also recalled trying to get emergency phone numbers from Clarke.

Ms. Koch recalls talking to Clarke while she was in the hospital giving birth to Shannon. Clarke emphatically stated not to give the phone numbers out because her parents did not know where she was and she wanted it that way. In that same conversation, Ms. Koch told Clarke not to worry about Timothy's homework. She knew Clarke just had a baby and that Timothy was doing fine. All three faculty members stated that Timothy was a good student, a seemingly happy child, with some missed attendance but never enough to be an issue. Ms. Koch said she was glad she had asked Ms. Philpotts to call the hotline. Timothy thanked her the next day.

The Follow – Up Assessment Case

When Nesmith determined that he had enough evidence to indicate the case, he involved the follow-up unit to help start services and determine if a case should be opened. Follow-up can have a 30 day assessment period to make the decision to open up a service case or not. The worker assigned was Marlon Bell. Bell completed a service plan, began a social history and kept case notes on the movements of the case.

On May 12, 1999, Bell wrote out a service plan. He cited the call on May 10, 1999, alleging Timothy's bruises and his fear of repercussion as the problem that came to the attention of the Department. Bell identified two areas where services would be needed: housing and assistance in parenting and discipline. The goal selected for the plan was remain home and the progress was to be evaluated in November of 1999. On the task sheet addressing housing, he included the tasks of certifying the family for Norman funds, assigning a housing advocate and the need for Clarke and Kemper to select a residence within their financial means. For services to address parenting and discipline, the tasks include a referral to Project 12 ways, Clarke and Kemper agreeing to participate in counseling, bringing Timothy when necessary, signing releases of information to share information between the agencies and Clarke and Kemper agreeing to meet with DCFS on a regular basis. Clarke and Kemper signed releases of information on May 27, 1999.

Marlon Bell made his first visit on May 17, 1999. Laura Harmon was at home, but Clarke and Kemper were not present. Harmon agreed to a CANTS and LEADS check. Bell documented an attempted CERAP. On

May 19, 1999, Kemper, Clarke and the baby met with Bell. Timothy was not present. The parents agreed to counseling and agreed to take responsibility for the report, but also blamed Timothy for causing trouble. Kemper explained that he used whipping because it was the next step in the progression of punishment, but he would not use it again, because Timothy did not respond to it as he had continued to lie. The parents agreed to call to arrange a time to gather information for the social history. Bell called the family twice on May 24, 1999, to set up an appointment. Kemper and Clarke agreed to come in on May 27, 1999. The following day, Clarke contacted Bell about an apartment they had found in the Corning area. Bell said his supervisor would have to approve it. On May 27, 1999, Kemper, Clarke and the baby came to the Allerton Field Office for the social history. Timothy was not present. Bell noted that Clarke appeared attentive and nurturing towards Shannon. Bell started the social history with information he received after meeting with Clarke and Kemper. The family composition was recorded as Kemper, Clarke and the children. He also included the Harmons, with whom the family was living, indicating that they had four children, and the putative father of Timothy.

Social Support Systems

Kemper reported that his relatives lived in Arizona. Kemper, he noted, had two other children who were both living with their biological mothers. Clarke's relatives lived in Illinois, in fact they had lived with some of her relatives before moving in with the Harmons. Clarke stated that the relationship with her family was strained because of her father's extra-marital affair and because her sister demonstrated more permissive child discipline than Kemper and Clarke. Bell noted that their values in child raising and marital fidelity have created conflicts with Clarke's family.

Discipline and Parenting

Clarke and Kemper told Bell that they were open to addressing parenting and exploring other avenues of discipline through counseling. They believed that Timothy's lying behavior precipitated the abuse and that they should discuss and explore techniques for handling that behavior. Bell judged that Kemper and Clarke appeared to have appropriate discipline and behavioral standards. The mother said that at the onset of the relationship between she and Kemper she disciplined Timothy. Kemper then stated that he had more influence in the discipline practices at the present time. Kemper said that he has vacillated about what his commitment level is to Timothy, as he was not Timothy's natural father, but he did want to invest in Timothy reaching his potential. As the social history addressed the issue of parenting, Bell wrote that that the parents appeared to demonstrate age appropriate expectations but blamed Timothy's behavior of lying to his teachers at school for the DCFS involvement. The parents denied that job stress or housing instability were precipitating factors. Kemper said he knew whipping was wrong but Timothy had a habit of lying and he had tried everything else. The parents admitted they went too far with the discipline by leaving marks.

Kemper and Clarke claimed they took great interest in Timothy's education; they set up a regular homework routine and kept in contact with Timothy's teacher and his school work improved because of it. Both parents valued their own education; Kemper had attended a year of college in Arizona and worked as a C.N.A. for the past four years. Clarke told Bell she had a nursing degree as well as clerical studies and secretarial skills education.

Health –Related Issues

Clarke worked until she was seven months pregnant with Shannon and then quit because of complications she had when pregnant with Timothy. When Clarke was pregnant with Timothy, she had eclampsia and gestational diabetes. Timothy was ill after birth and needed to be on a ventilator. The mother reported that Timothy had health problems until he was three years old and that she had mental health problems following

Timothy's birth. Timothy was born in late August 1991. She was hospitalized twice for suicidal ideation in 1992 and 1993 and participated in outpatient treatment throughout 1993. Clarke stated there was no other history of mental illness in her family. Kemper reported there was no history of mental illness in his family.

The last section that was completed in the social history addressed the family's perception of the child. Bell noted that Clarke and Kemper blamed Timothy for lying at school which brought about the DCFS involvement. The impact of the indicated report, he wrote, could cause Kemper to lose his job.

On June 17, 1999, Bell met with his supervisor Deena Rodman. Rodman told Bell to close the case based on the family avoiding the caseworker and demonstrating that they do not want services. Bell was to first check if Nesmith had seen the family at their new address. Bell then found out that the family had indeed moved. Bell later received a call from Nesmith who had attempted a visit at the new address. Nesmith called again after seeing Clarke and Kemper who again refused services. Bell called the housing advocate to inform her that DCFS was closing its case as the family refused services.

Record of Visits After Enhanced Referral to Follow-up From DCP

Date	Visit	Met With
May 17, 1999	**First attempted visit**	Family not home; met with Laura Harmon
May 19, 1999	**Home visit**	Met with Kemper, Clarke and baby. Parents agree to counseling, take responsibility, but blame Timothy's lying and behavior for the report
May 27, 1999	**At DCFS Office**	Met with Kemper, Clarke and baby, gather information for social history
May 28, 1999	**Telephone Contact**	Bell informs family Norman funds not approved. Clarke and Kemper complain that DCFS lied to them, they refuse to participate in services
June 4, 1999	**Attempted Visit**	Met with Timothy and Laura Harmon; Clarke and Kemper not home
June 8, 1999	**Attempted Visit**	No response
June 9, 1999	**Attempted Visit**	Met with Harmon; Clarke and Kemper not home
June 11, 1999	**Attempted Visit**	Met with Harmon; Clarke and Kemper not home
June 16, 1999	**CPI Pender attempts visit**	No one home, leaves card. Receives a call from Harmon stating Clarke and Kemper moved.
June 17, 1999	**CPI Nesmith attempts visit at new address**	No response, checks with neighbors to see if a new family moved in
June 18, 1999	**CPI Nesmith visits new address**	Met with all family members, informed them the report would be indicated, offered them services, services refused

ANALYSIS

A major purpose of OIG death investigations is to see if future harms can be prevented. The Department knew that Timothy had been physically abused in May of 1999. Charles Kemper did not deny using excessive force when punishing Timothy for lying. Nesmith indicated to the OIG that he made it clear to Kemper that using an electrical cord to whip a child was abuse, not merely corporal punishment. Other information that was available to DCP and DCFS was not followed up, considered or perceived differently in deciding how to handle the case. Both investigators and follow-up workers depended on impressions and assumptions to support their assessments. No one appeared to consider the competing hypothesis of serious risk to Timothy. DCP and DCFS workers collaborated to locate the family after they moved, but never integrated and analyzed the cumulative information they had discovered in the course of the investigation and assessment process. There was enough information on the family that, if integrated, would have raised the level of risk.

The exposure-adjusted rates for both re-abuse and/or neglect of children living with parent(s) or caretakers shows that for children under 12, the risk for re-abuse/neglect increases steadily down to the youngest. For children over 12 the risk of re-abuse or neglect decreases steadily. Children up to the age of three have the highest rate-24.6 per 100 children involved with DCFS for a year.[2] For six to nine year olds the rate is 11.2; whereas for 15 to 18 years olds the rate is 4.9.[3] More enlightening are the rates for the subset of children who experience another incident of physical abuse. Within that subset the group of children with the highest rates of re-abuse are children six to nine years old. Children six to nine years old have a re-abuse rate of .9 per 100 child years. Children under six have a .7 re-abuse rate and children 9 to 12 have a re-abuse rate of .8, again higher than the rate for children under six. Approximately 14% of cases come into the system for physical abuse.[4] Knowledge of re-abuse rates on the 14% of children indicated for abuse would prove more practical to child welfare professionals. However, the LEADS protocol and the definition of the cuts, welts and bruises allegation may have left DCFS staff with the impression that children over the age of six are at less risk and able to protect themselves. While school age children have more access to other adults and are verbal enough to tell someone when they are being injured, as with domestic violence cases, they may not speak up because of fear. The ability of a six, seven or eight year old to protect themselves is far below that of an adolescent.

Investigation

Problems are evident in examining the A sequence investigation. The investigation revealed enough evidence to indicate the case, and a possible hypothesis as to the source of stress: lack of adequate housing and

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[2] The indicator used by researchers at The University of Illinois at Urbana-Champaign was defined as the "rate per 100 children in care for 1 year with an indicated report in a family case per fiscal year." This was then shortened to 100 child years. It should be noted that they use the term children in care to be DCFS involvement with their family as opposed to children in substitute or foster care.

[3] The data was taken from "Report on Child Safety and Permanency in Illinois for Fiscal Year 1999". The report was generated from the Children and Family Research Center at The University of Illinois at Urbana-Champaign School of Social Work.

[4] The rates for the subset of re-abuse are rates based upon the re-abuse of the total number of children living in family cases in FY 99. The rate calculates re-abuse as a percentage of all children living in family cases which includes all allegations of abuse and neglect not only physical abuse. A better measure would track families (the 14% whose family comes to the attention of DCFS for physical abuse) who were reported and indicated with physical abuse allegations to determine what rate of those children are victims of physical re-abuse within a given period of time.

perceived behavior of Timothy. In the FAFW, Nesmith also listed the birth of Shannon, who was born with pneumonia, as a possible stress factor. The investigation over-relied on the self- report of the mother and the perpetrator.

No In-State or Out- of-State LEADS or Out-of-State CANTS Check

Underneath present policy and procedure, an out-of-state CANTS check is not required in an investigation. At the beginning of the investigation, it was determined that Timothy had transferred to Maxwell School when his family moved from Arizona. The Arizona CANTS information would have changed the course of investigation and affected the decision about Timothy's safety. Gathering this information constitutes good investigative practice. There was no attempt to contact Arizona to determine if Kemper or Clarke had a previous child abuse or neglect charge nor to run a LEADS check for Arizona as well as Illino is. Nesmith told OIG staff that he knew Kemper and Clarke had recently moved from Serazen, Arizona. DCP supervisor Lynn Heard and follow–up supervisor Deena Rodman readily admitted that such a check should have been done. Nesmith told the OIG that he has contacted other states in the past. Heard also noted the mistake in her own analysis of the case that she wrote immediately after the death of Timothy. Heard agreed that there was no excuse for the checks not having been done. They have called Arizona and other states in other cases when an alleged perpetrator had recently moved. Nesmith explained to OIG staff that he relied on Kemper's C.N.A. certificate from the Illinois Department of Public Health presented to him.

The certificate stated: "Last Criminal Background Check 4/1999 Results: No Disqulaifying Conditions." [5] This information was a mitigating factor in the case. Nesmith told OIG staff he saw that certificate and believed that Kemper had cleared a certified background check that noted Kemper was "deemed Competent-FL" and had no indicated "Abuse", "Neglect" nor "Theft" "Findings." He accepted the face validity of the certificate not knowing the limitations of the background checks. In reality the qualifiers on the certificate, by statute 225 ILCS 46 et seq., are limited to the State of Illinois.[6] Because it was limited to Illinois data the certificate did not provide a reliability check on the character of Kemper, who had both indicated reports of abuse in Arizona and a criminal history of being arrested for domestic violence.

Collateral and Household Members Interviews

On a first take, Kemper and Clarke presented well. They presented as a struggling, hardworking couple. Both attained some level of college education and were working in fields of the helping professions that were not high paying. The couple appeared articulate and apologetic. They acknowledged their punishment of Timothy was excessive and readily signed an agreement to not use such form of punishment again. Nesmith was unaware, since there were no collateral interviews, that their disciplinary techniques had previously caused conflict with Clarke's sister. Initially they stated that they found lying unacceptable and were trying to teach Timothy that it was wrong. Over time it became apparent that they found lying intolerable.

Nesmith told OIG staff he had completed the new DCP training and felt he did a good job in engaging the couple. He thought he had a good read on them. However, his assessment was based on impressions. Outside of the reporter and source there were no collateral interviews. Rules require collateral contacts if that person would have relevant information about the incident or family circumstances. Nesmith did not pursue information about the family circumstances from extended family members or inquire of Bell if other risk

[5] The OIG obtained a copy of this certificate from the Illinois Department of Public Health and confirmed the information. See Appendix A.

[6] The criminal background checks are done through the Illinois State Police who contracts with other state agencies (including DCFS) to do criminal background checks. The OIG called the Illinois Department of Public Health who confirmed that the criminal background check covers only Illinois.

factors had come to light. Clarke and Kemper mentioned her family as one of the reasons for moving to Illinois, indicating that family may have had knowledge of their circumstances.

Contrary to Procedures, Nesmith did not interview the Harmons and their children, members of the household at the time of the initial investigation. The Harmons, though seen by Bell, (and Bell did run a LEADS and CANTS on them) were never directly asked about how Clarke and Kemper treated Timothy on a regular basis. There is no guarantee they would have voiced concerns but that does not excuse DCP or follow up from seeking this information. Collateral information may have changed the level of risk assigned. A higher level of risk would have assured that a safety plan would have been put in place.

Addition of the Inadequate Shelter Allegation

Inadequate shelter is defined within DCFS rules and procedures as "lack of shelter which is safe and which protects the child(ren) from the elements." While the family was, at the time the report was made, living with another family, there was no documented evidence that the housing was overcrowded or that the Harmons had told Clarke and Kemper that they would have to leave. Nesmith described the apartment as small, but gave no further details. Bell described the housing as being structurally sound. No other documentation noted that the residence was in any way harmful to the children living there. However, Nesmith was able to engage the couple by offering them Norman funds to help them with housing. Norman funds were created to help families who, because of poverty issues, came to the attention of DCFS. Clarke and Kemper came to the attention of DCFS because of the bruises on Timothy, not because of inability to clothe, feed or shelter Timothy or Shannon. In theory, lack of their own home may have caused stress related to disciplining Timothy, but in reality no evidence surfaced to support that hypothesis. Clarke and Kemper themselves told Bell that lack of housing did not contribute to their abusing Timothy.

However, contrary to the level of risk noted in the FAFW and the description of the case in the interviews with OIG staff, Nesmith and Heard signed off on the Norman Certification. Two questions in the certification process relate to having reason to remove the children. The first question asks if the "overall risk to the children" is at a level high enough to consider removal. The next asks if the allegation that would allow Norman Funds to be used (i.e. inadequate housing) gives sufficient reason for removal. Both inquiries are answered yes. The discrepancy suggests that the level of risk on the FAFW was rated too low or that Norman Funds were being used as a way to engage the family through the use of concrete services. If the latter were the case, this would have been an inappropriate use of Norman Funds. If the former was true then a safety plan should have been utilized.

Other Services: Health and Mental Health

While DCFS worked to attempt to provide housing for the family, other service areas were not addressed. Nesmith noted in the FAFW that having a newborn with pneumonia may have been a stress factor for Clarke and Kemper. Yet there was no referral for a public health nurse or supportive services to assist in the care of the baby or any further investigation regarding the medical care the parents had set up for Shannon. Bell elicited reports from Clarke about past problems with depression after the birth of Timothy. The possibility of post-partum depression was not explored. In addition, the mother's separation from Timothy both physically and emotionally, because of her history of hospitalization in his early years, was not thoroughly analyzed. His maternal grandmother may well have become his surrogate mother as often is the case when a mother suffers from depression. Throughout the record there is not one positive statement Clarke makes about her son Timothy. The mother, having no positive image of Timothy, may have been a sign of emotional distance to be further explored and should have been considered as an additional risk factor.

Inconsistent Information

Examination of the social history information gathered by Bell revealed areas of concern and inconsistencies. Clarke had reported to Nesmith that her family was from the area and one of the reasons they had moved was for the support of her family. Bell was told by Clarke and Kemper that they do not associate with her family because of conflicts about disciplining children and marital fidelity. Such information, discovered during an open investigation, should have prompted a collateral contact for two reasons: prior residence in the recent past and information on discipline. Further, the apparent conflict regarding discipline speaks directly to the reason that DCFS became involved with the family.

There has been research examining the relationship between perception of behavioral problems and maltreatment of children. By using behavior inventories and behavior checklists,[7] some research has found that abusive parents perceive their children as having more serious behavior problems than non-abusive parents (Wolfe, 1985). The perception of their children as having serious behavioral problems might indicate unrealistic parental expectations, low tolerance for problematic behavior, or children who do have serious behavior problems. By checking the child's behavior in settings outside of the home, especially school, it allows an investigator to better assess the reality of the parents' perception. In the Clarke case, the parents seemed adamant that Timothy was lying about school and that the behavior was most serious. Yet neither his teachers nor the principal at Maxwell School voiced concerns or complaints about Timothy's behavior. What we know through interviews with Clarke's sister after the death of Timothy was that Kemper and Clarke would drill Timothy on schoolwork to the point where the concern voiced by a relative caused a family conflict.

Just as troubling is the perception of the behavior and discipline standards of Kemper and Clarke by DCFS staff. It is important to consider in the assessment process the question: is the abuse condoned because it serves a reportedly higher principle (Encyclopedia of Social Work, 1999). The worker perceived the couple's devotion to raising a "good" (non-lying) child who was capable of high academic achievement as mitigating circumstances to the abuse incident. The unquestioning acceptance of the parents' explanation for the beating suggests that the investigators turned a blind eye to the abuse. An unclouded assessment of the risk factors would have determined the "purity" of these expectations increased risk for this second grader.

The OIG investigators discovered,in an interview with Timothy's teacher, that she had told Clarke not to worry about homework because of the recent birth of Shannon. The inconsistencies of Clarke's and Kemper's preoccupation with school versus his being an A student, with no complaints from the teacher should have been further explored. The expectations for the child's developmental level may have been unrealistic, again raising the risk level.

DCP and follow-up worked as a team to try to get services to the family. Follow up contacted DCP after the family moved without notice, but the communication never went beyond location although follow-up had gathered more information about the family. DCP did find the family. Nesmith found the home satisfactory, although he did not check Timothy for other injuries or speak to him alone. Nesmith again attempted to engage the family in accepting services, but they refused. Nesmith reported his finding to follow-up; DCP closed the investigation with an indicated finding, follow-up closed their assessment as voluntary withdrawal. If follow-up had shared the information they gathered in the social history with DCP, that may have prompted Nesmith to do some further investigation.

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[7] Examples of such tools include the Eyberg Child Behavior Inventory (Eyberg & Ross, 1978) and the Child Behavior Checklist (Achenbach, 1991, 1992)

The Follow-Up Case

Opening a service case is often based upon a thirty-day assessment by follow-up. The assessment begins with a review of the Family Assessment Factor Worksheet. A high risk rating dictates that follow-up should make an attempt to see the family within twenty-four hours. A low risk rating dictates that follow up should make an attempt within five days. The Clarke case was a low risk rating and Bell attempted twice within five days to see the family. The case was closed after the thirty-day assessment period ended because Clarke and Kemper refused services.

Follow-up supervisor Deena Rodman told the OIG that it was her decision to close the case. Rodman stated that she takes responsibility for the decision, that Bell closed the case because she told him to close it. Bell had come to Rodman after Clarke and Kemper moved without notice. After Nesmith found the family and they refused services, Rodman believed they could go no further. She told OIG investigators that the computer has it closed out on June 12, 1999, which falls under the thirty-day assessment period, even though they did wait to see if Nesmith could get the couple to accept services.

DCFS does not have the authority to force parents into services; they need the court to enforce case plan services. Rodman explained that when a parent chooses not to accept services the worker and supervisor could write to the states attorney and request a protective order from the court ordering the parents into services. The process generally takes at least three months because subpoenas have to be issued for a future court date. (Though it has taken longer when, for example, the court has not been able to serve the parents).

Rodman and Bell told the OIG they saw problems with the case and felt that the family's need for services went beyond housing. Rodman noted that this was a blended and mixed family with the paramour doing the discipline. Also, Kemper and Clarke blamed a little boy for DCFS involvement. Yet again, without a prior history of abuse they believed it was a forgone conclusion that they did not have enough for the state's attorney to file a motion for an order of protection. Rodman related to the OIG that the follow-up division is at a disadvantage in certain areas. For example, Rodman believes that follow-up cannot get information on child abuse and neglect reports from other states without a release of information, only DCP can get that information without a release as part of an investigation. Also, because of confidentiality, follow-up in an intact family case cannot go to schools and other people for information without a release of information. Bell felt he needed to get the Harmons' permission to run a CANTS and LEADS check on them even though there was an open investigation. Further, it is DCP that assigns the level of risk. In the Clarke case the level of risk assigned was low. The case was opened however, for assessment. Follow-up cannot escape responsibility for assessing risk to Timothy simply because it was not properly assessed by DCP. DCP failed to adequately assess risk, in part because the parents admitted the abuse. As a result, the allegation could be indicated without an investigation of issues such as the existence of a pattern of abuse. It then became incumbent on follow-up to make this determination.

Inevitably the question arises as to whether DCP would take protective custody ("PC") in an A sequence physical abuse case. Fiscal year 99 ("FY99") statistics for three Southern Region Counties: Franklin, Johnson and Williamson Counties,[8] show approximately 11% of the A sequence reports for cuts, welts and bruises that were taken for investigation were indicated. PC was not taken in any of those indicated cases. PC was taken of children in A sequences cases, only when a report was taken for multiple allegations. (*See table below*). Only by looking at the individual cases in the statistics would one be able to differentiate the best response. *The use of this data is not to say that PC should not have been considered but it is used as a backdrop to look at the likelihood, under current practice, that PC would have been taken on an A sequence case alleging cuts welts and bruises.*

[8] The OIG obtained the statistics from the DCFS Division of Quality Assurance.

A Sequence Investigations Involving Multiple Allegations including Cuts, Welts and Bruises in Franklin, Williamson and Johnson Counties for FY 99

	Reports taken with Multiple Allegations Including Cuts Welts and Bruises	**Indicated Reports with Multiple Allegations Including Cuts, Welts and Bruises**	**Indicated Reports Resulting in Protective Custody**
Franklin County	20	2 (10%)	1 (5%)
Williamson County	45	19 (42.2%)	5 (11%)
Johnson County	8	7 (87.5%)	3 (37.5%)

Confidentiality

During OIG interviews, the follow-up worker and his supervisor both expressed inappropriate concern s about confidentiality that they claimed limited their ability to assure Timothy's safety. It is unclear whether these concerns drove decision-making in this case or whether they were simply afterthoughts to excuse the naive acceptance of the parents' position in this case. It is useful, however, to discuss the confidentiality issues raised, since they represent an increasing set of problems identified by the OIG, in which inappropriate concerns over confidentiality appear to predominate over child safety concerns. In this case, the supervisor stated that the grandmother could not be given information on the family's whereabouts because of confidentiality. The worker believed that he could not perform a criminal history or CANTS check on the couple that were living with Timothy without the couple's consent. The worker also believed that he could not perform an out-of-state CANTS and criminal history check on Kemper and Clarke without their consent.

Client confidentiality is a difficult subject for caseworkers because there are at least seven separate statutes that determine whether information can be shared and with whom. A caseworker must first decide what type of information needs to be shared, then, what statutes apply and with whom the statutes allow the caseworker to share the information. It is the job of management and lawyers to parse the statutes, comprehend their application to daily casework and translate that comprehension to caseworkers in a manner that they can apply in their daily work. We have seriously failed in this job. Rule 431 is silent on the difficult questions such as how much can we tell concerned family members and when. Workers are constantly warned about what will happen if they reveal confidential information. The result is that many workers are so confused about confidentiality that they respond by not addressing safety concerns. Workers need to be told, at a minimum, that their primary job is protection. Protection of children should motivate all decision-making. If they believe that they cannot reveal information relevant to child safety, they need to consult their supervisor. If the supervisor believes that the law requires that necessary information cannot be shared, the supervisor needs to confirm that conclusion with a call for legal advice.

In this case, *if* the worker had appropriately assessed a safety risk to the child, he could certainly have determined that the grandmother needed to be included in the safety plan to decrease isolation and provide another set of eyes. Cooperating with the grandmother would then have been a task in the service plan and the parents' exclusion of her could be viewed as non-cooperation. Similarly, CANTS and criminal history checks of everyone in the home, and out-of-state checks, if warranted, must be completed and do not require

consents.

Physical Abuse Cases

The determination was made that the abuse was an isolated incident, occurring out of the stress of a move, living with another family and dealing with a behavior (lying) that Kemper found unacceptable. Essentially, the intent was punishment but the result was abuse. Perhaps it was this determination that guided the course of the DCFS involvement that followed.

Physical violence, unlike neglect behaviors, is not a high frequency behavior. DCFS would better serve children by determining what type of monitoring efforts and for how long they are needed for a true safety net for the child. The critical factor in determining risk of further abuse is whether a pattern of abuse, neglect or injury exists. In the DCFS Manual for Mandated Reporters, it asks mandated reporters involved in physical abuse investigations to note: location of the injury, severity of the injury and patterns of similar injuries over time. The manual notes that it is helpful for investigators if the reporter has information regarding any pattern of abuse. If the Department wants reporters to note any patterns of abuse, it behooves DCP investigators to also try to determine if there is a pattern of injuries or abuse. The fact that a report came in as an A sequence does not automatically negate a pattern of abuse existing. Child Welfare League of America data shows that abuse more often than not is a hidden phenomenon. A solid investigation should attempt to rule out a pattern, not merely accept that a pattern does not exist. In the Clarke case, there was not a thorough investigation to determine if a pattern of abuse existed, except for using the self-report of the parents and the school not having noted any earlier incidents. Timothy had attended the school for only a few months. However, the teacher told the OIG investigators that Timothy was always dressed in long sleeved shirts and pants, even in hot weather.

Safety plans in physical abuse cases need to be strong enough to ensure safety. Children should be seen often by an outside support system to ensure the child is not at risk of being re-abused. In the case of Timothy Clarke, the case was closed at the point when even fewer people would be seeing Timothy than before. School was closed for the summer, eliminating the safety net provided by the school. Timothy's mother and her boyfriend had moved out of the home they were sharing with another couple, further isolating Timothy from other adults. Finally, no use was made of Timothy's extended family. The maternal grandmother told the OIG investigator that she was not able to find the family and she was worried about Timothy. She stated that she called DCFS and DCFS would not help her, citing confidentiality.

The reason the grandmother was so critical is that Timothy had spent much of his early life in the care of his grandmother, and she was willing to watch him. DCFS needs to enlist the help of relatives like the grandmother. A child development specialist suggests that children should be asked "who are you special to" to give ideas on what protectors can be in the formal or informal support system. Making such arrangements means negotiating with the family as to who can provide the further protection. In order for physical abuse cases to remain intact other safety factors must be put into place.

Joel Nesmith told the OIG investigators that he did not feel a safety plan was necessary, he felt the written agreement that Kemper would not use the punishment on Timothy again, along with Clarke's agreement to the plan was enough. Yet, research on the use of contracts shows that they are not useful unless they are monitored. The fact that Timothy was abused, but did not, according to Nesmith, rise to the level of taking protective custody, means a true safety plan must be put in place. A promise, especially from someone who has abused a child before, is not a safety plan. Two options for a safety plan were immediate to the situation. The family was living with the Harmon family at the time who could have been asked to contact DCFS if other incidents of abuse occurred. Further, relatives of Timothy should have been considered for the safety

plan.

The presumption must be that if a child was hit violently once, it will reoccur. This does not mean that children must always be removed from their families. It does mean, however, that protective measures must be put in place until services are complied with. The problem here was that every one simply believed the parents when they said it would never happen again. Since the Department is charged with protecting children we cannot base our actions on "impressions" and unsupported "beliefs".

Contextual Dilemmas

Within the last few years, the Department tested several new models of organizing and carrying out the functions of its child protection investigations and the delivery of services to families whose children remain in the custody of their parent(s). The "Redesign" pilots were to assure greater safety to children and avoidance of placement of children into state custody (Hornsby & Zeller, 1998). The Department premised that by delivering and linking services to families more quickly, children could safely be diverted from state custody. Researchers for the pilots reported that the Department's staff offered crisis theory as a partial explanation for the high incident of repeat neglect and abuse. Staff believed that the crisis of the event that brought the family to DCFS' attention could act as a motivating factor for cooperating with services. With the crisis gone, the family declined services, increasing the risk of re-abuse. The "Redesign" pilots removed organizational barriers that delayed services. Process measure included the speed and frequency of services. Outcome measurements included re-abuse rates and percent of children taken into temporary custody.

Prior to these pilots, the Department had revamped its child protection training. The new training design incorporated a safety risk factoring system and focused child protection on the inter-personnel skills necessary for engagement of families. The results were an overall increase in the timely delivery of services and a decrease in re-abuse and neglect rates. Both projects targeted broad indicators and did not specify the small subgroup of physically abused children under the age of ten who remained in the custody of their parent(s). Neither of these events was intended to supersede the investigative procedures as established by Rule 300. However, it appears that in the Clarke case critical investigative procedures were sacrificed under the impression that quick delivery of services and engagement of the parents were more paramount then a thorough investigation into the family circumstances. Compounding this problem, there appears to be an over-emphasis on the engagement and inter-personal process with little recognition of the fact that *some parents are not credible or truthful.* The training manual's example of a physical abuse case elicits an intuitive response that the parent's reaction to the broken lamp was more likely than not a single reactive event. Such simple truths are seldom the case in abuse cases.

A blended approach with no clear line between investigations and protective services can safeguard risk to children if the full facts of the situation and family circumstances that brought the child into harm are investigated, evaluated and monitored by the cooperating professionals. It is the thorough investigation that provides the necessary precondition for determining if services match the safety needs of the child by reducing or mitigating risks of re-abuse. A prudent approach is the younger the child, the tighter the safety net should be for that child.

In the blended period when both the investigator and the enhancement worker were on the case, information surfaced that Timothy's mother and her partner avoided Timothy's extended family because they disagreed on methods of child discipline. This critical information directly related to the allegation at hand. Yet, none of the professionals heeded this information to determine whether Timothy would be at increased risk because adults had intervened in the past to no avail. His aunt, with whom he had lived just prior to the abuse incident, was never contacted. The child was never asked if he felt safe when he lived with his aunt or *his* other family members. Rather, he was left in increasing isolation with a mother and partner who blamed him for possible

loss of potential employment, found him to be inadequate in his school performance despite his achieving A's, and who described him as being a liar. Within 31 days of an assault, protective services closed the case because his caretakers refused services. The risk had not been mitigated; rather, isolation was increased.

It is confounding that someone could investigate a case in which someone hit a child hard enough to leave multiple bruises and welts and have enough evidence to indicate the case for child abuse, but allow the perpetrators to refuse services and then simply close the case. DCFS should inform parents that refusing to accept services will not affect the determination of a case. The indication is based on the facts of the case. However, the Department has the option of requesting the courts sanction to elicit the cooperation of the parents with a safety plan that is in the best interests of a physically abused child. If a child is at risk and the parents are uncooperative, the Department must either take protective custody or screen the case for a court order. If a child is not taken into PC for fear that a judge would return the child, or a case is not screened into court because of the belief that a states attorney will not accept the case DCFS is letting perceived barriers guide decisions on child safety. A judges ruling can be appealed, a states attorney can be asked what additional information is needed. These situations, though stark examples, are not the only example of the Department citing barriers to assuring child safety. A recommendation by a Child Death Review Team stressed the need for workers to obtain verification of identifying information used for CANTS and LEADS checks. The Department agreed with the recommendation, but added that "unfortunately there are circumstances where the subject of the investigation has no legal requirement to provide that verification."[9] A CANTS and LEADS check is vital to assess risk. If subjects of an investigation refuse to provide verifying documents, the Department must seek such cooperation through the courts. DCFS must make attempts to do what will keep the child safe even if another agency of the state may act in a different manner.

Conclusion

This case represents a failure to appreciate competing hypothesis. An eight year old with welts and bruises may signify a one- time punishment gone awry or it may be a sign of an abuser who is out of control. We cannot base a determination of which scenario is correct solely on parents' or alleged perpetrators self-report. It is understandable that a DCP investigator, under the pressure of short timelines, may choose a quick indication based upon a parents' admission. No one should presume, however, that the indication tells the full story. In Timothy's case, no one ever determined the depth of the abuse problem.

In the end, the fact that the A sequence report was indicated for abuse appeared to be an exercise in futility. Nothing had changed, except the residence of the family, which further isolated the child. The family circumstances remained the same. The perpetrator was still in charge of discipline and the parents' perception of the child had worsened. There appears to be a culture of reticence than prevents DCFS from going out and assertively learning more about the family. This culture creates an undertow that weakens the primary function of protecting children. This is what Timothy had feared most.

Recommendations

1. DCFS should amend policy and procedure to add a rule stating that the Department must make an independent inquiry of child abuse/neglect indications in other states when an adult member of the household has lived in other states within the last five years. Such an inquiry should be made whenever information is discovered that an adult household member has resided outside Illinois. If the follow-up division finds out such information, the DCP manager should be informed and ensure that such an inquiry is completed. The LEADS protocol currently requires that an out-of-state LEADS check be conducted whenever there is reason to suspect that a subject of a report has a

[9] Information from Child Death Review Recommendations Cook County Team A, ME# 286.

criminal record outside of Illinois. DCP should always make an independent inquiry of CANTS and LEADS in Illinois (even if a certificate, license, or other document is presented that previously required such checks to be completed).

2. DCFS should not close cases, where there is an indicated finding of abuse, on the basis that the parents or caretakers will not cooperate with services. If the caretakers will not cooperate, DCFS needs to attempt to screen the case into court and continue to try to monitor the safety of the child(ren) while the court petition is being filed. Because of the caretakers' lack of cooperation, such monitoring may include attempts to visit the child in school, day care or other such settings. DCFS should fully document all attempts to contact the caretakers and provide services. If the State's Attorney's Office refuses to file, DCFS should document the reason(s) why and what further information the SAO states is necessary to file a petition.

3. Child abuse and neglect is as much a public health issue as a social work issue. The Department of Children and Family Services first came into contact with Timothy Clarke after a teacher from Maxwell School saw his bruises and called the hotline. Because the faculty and staff at the school were then aware of Timothy's abuse, they were able to be alert to further signs of abuse. When Timothy moved to his new school, information about his past abuse did not follow him. Thus, faculty and staff in his new school were not on heightened alert for possible signs of abuse or excessive absences. To help protect other children in the future, the Department should work with the Illinois Department of Education and the Illinois Department of Public Health to have indicated abuse or neglect that was reported by school faculty or staff noted on a student's permanent health record that transfers with other school records when a child changes schools. This will inform the new school that the child has been a victim of abuse or neglect in the past and the staff, as mandated reporters, should be attentive to signs of abuse or neglect and excessive absences.

4. The Illinois Department of Public Health issued a certificate to Charles Kemper that indicated Kemper had no indicated child abuse or neglect reports and no criminal convictions. The OIG requests permission to share this report with IDPH to discuss a change in the certificates to include a disclaimer for out of state safety checks.

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

6. DCFS should advise supervisors that whenever legitimate casework or clinical concerns dictate sharing information, but it appears that concerns over confidentiality do not allow such sharing, the supervisor must contact DCFS Legal, who will document both the call and the answer given to the supervisor. The OIG would like to monitor these calls as part of a continuing investigation of casework confidentiality issues.

7. The OIG concurs with the recommendations submitted to Director McDonald from the Allerton Child Death Review Team.

8. The OIG requests permission to share a redacted copy of this report with the agency that develops child protection training materials.

Department of Children and Family Services
2240 West Ogden Avenue
Chicago, Illinois 60612
(312) 433-3000

OFFICE OF THE INSPECTOR GENERAL

REDACTED REPORT

This report is being released by the OIG for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names are fictitious.

File No.: 97-1513
Subject: Death Investigation
Minor: Matthew London Jr., DOB: 1/15/98; DOD: 6/23/98[1]

Biological Parents: Donna Burwood, DOB: 6/12/80
Matthew London, Sr., DOB: 10/1/79

DCFS Personnel: Mitchell Clark, DCP Investigator for A sequence
Jack Royster , DCP Investigator for B sequence
Annabelle Mayhew , DCP Supervisor

Progressions Personnel: Gregory Yellen, Therapist
Aaron Gentry, Supervisor
Robin Bradley, Outreach Worker

Summary of Complaint

Five-month old Matthew London, Jr. died on June 23, 1998. The Fullham County Coroner determined that the infant died of internal bleeding caused by blunt trauma to the abdomen with a secondary cause of blunt trauma to the head. There was evidence of external trauma. Matthew, Jr. had bruises on his abdomen, back, left leg, left cheek and forehead. The Coroner's jury found that Matthew, Jr.'s death was a homicide. The infant's father was charged with first-degree murder and is awaiting trial. The OIG investigated this child's death because his family had an intact family case open at the time of his death.

[1] The investigation and report of this child's death was delayed because of the lengthy completion of records that had to be collected (e.g., DCP and police reports) and the reluctance of witnesses to give information due to the upcoming criminal trial.

Background

Matthew London, Jr. was born to 17-year old Donna Burwood and 18-year old Matthew London on January 15, 1998. Matthew London and Donna Burwood were high school sweethearts. The couple lived together in the Crestwood Trailer Park in Dolan, Illinois. They had been together for three years when Matthew, Jr. was born.

London left Crown High School in 1997. He had been a star football player for the school and had been considered for a college scholarship out of state. This opportunity did not come to fruition because of London's poor academic record. London remained one credit short of graduation requirements and did not graduate. After leaving school, London never settled into steady employment or education. He was the primary caretaker for Matthew, Jr.

Burwood, a year younger than London, graduated early from Crown High School in January 1998. Her academic counselor stated that Burwood had college potential and her parents reported that she planned to enter college. A few months before Matthew, Jr. was born, Burwood and London moved into a trailer home that Burwood's parents purchased for them in the Crestwood Trailer Park in Dolan. Burwood worked 25-30 hours per week at a telemarketing firm.

There is evidence that tension existed between Burwood's parents and London. In January 1996, Dolan Police documented that London reported that "his girlfriend's father [Mr. Burwood] had told London to stay away from his daughter.... and he [Mr. Burwood] would have people watching him [London] at school." Mr. Burwood had called his daughter's high school counselor to ask her to intervene with Burwood and London. Based on police reports and calls from Mrs. Burwood to DCP and Progressions, it appears that the Burwoods' relationship with their daughter was also strained, at least in part because of her involvement with London.[2]

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[2]On May 5, 1997, someone from the Burwood family residence called 911; Mrs. Burwood stated that they were having trouble getting their daughter to go to the hospital for behavior problems.
On July 1, 1997, Burwood's car was stolen. She reported to police that she thought her father took the car because he was angry that she moved out; her parents were holders on a personal note for the purchase of the car. When the police interviewed the Burwoods, they told police that they did not take the car but that they were concerned about their daughter. The police report states that Mr. Burwood stated that his daughter was pregnant with a Negro baby.
On June 3, 1998, when the CPI interviewed Burwood she acknowledged that her parents had been upset about her dating London the year prior, although they were getting along at that time.
On June 9, 1998, Mrs. Burwood called the CPI to report that she feared her daughter was being abused. She asked the CPI to tell Burwood that she could come home.
On June 24, 1998, the day after Matthew, Jr. died, Mrs. Burwood called DCP. The DCP supervisor recorded that Mrs. Burwood stated that she and her husband thought that their daughter would stay the night with them, however, she left their house and they didn't know where she was. Mrs. Burwood also reported that London's mother had hit her at the hospital and that she hit her back. Mrs. Burwood was asked to leave the hospital. Mrs. Burwood told the DCP supervisor that she had always "hated" London; she resented him for not supporting his family.
On June 24, 1998, an investigator for the Fullham County Coroner told the DCP supervisor that he "was struck by the lack of warmth between Donna Burwood and her parents at the hospital. He stated 'there was not much love lost' on either side and that he observed that they spent little time together that evening."
On June 29, 1998, the Progressions therapist told the CPI investigating Matthew, Jr.'s death that he had spoken with Mrs. Burwood several times; she had told him that she "hated" London and felt he was not interested in employment or doing a great deal to provide for his family.

In a telephone interview with an OIG Investigator, the high school counselors of Burwood and London stated that many students had reported to them that London was verbally demeaning to Burwood. London's sister had told counselors that London treated Burwood "like a dog." Once Burwood's high school counselor overheard them fighting in the hall. She arranged for Burwood to visit with a sex assault expert who had spoken at the school to assist in determining if Burwood had been abused by London. Burwood denied to the sex assault expert and to her school counselor that she was physically abused. The school counselors also confronted London who likewise denied that any abuse was occurring.

DCP Investigation

On June 2, 1998, one of Donna Burwood's co-workers called the State Central Register (SCR) to report suspected abuse of four-and-a-half-month-old Matthew, Jr. by his father. London had just visited the office with Matthew, Jr. who had two black eyes. Veteran Child Protective Investigator (CPI) Mitchell Clark was assigned to investigate.

CPI Clark initially interviewed three of Burwood's co-workers. All three co-workers told the CPI it was common knowledge in the office that Burwood was being abused by London; Burwood often had bruises which she explained had come from arguments between herself and London.[3] All three co-workers stated they had encouraged Burwood to leave London. One co-worker opined that Burwood was afraid of London; the co-worker described him as very controlling.[4] The other two stated that Burwood had told them of an incident where London "hog-tied" the baby with an electrical cord; one of them related that Burwood had said London could be jealous and that is why he tied the baby up.[5] On another occasion, when Matthew, Jr. was four months old, they had seen a bruise on the baby's face; London had explained to one of them that it was from a fall. Another time the co-workers said Burwood told them that London hung the baby by his arms over the crib.[6] One of the co-workers reported that London would lock himself in a room with the baby and not allow Burwood to see them.

DCP asked the police to go to the Burwood-London home that evening. The report of June 2, 1998, 7:35 p.m. reads:

> R/O responded to the residence, in reference to a message left for the midnight shift to check for suspected child abuse...R/O met with the father of the baby, and did view the baby. The complaint had been that the child had bruising under both eyes. The father explained to R/O that the child fell on Wed. May 27, 1998, while at home and inside the bathtub. He said that he was giving the child a bath and while doing so, the child fell a short distance. The father said the child had a small cut under his right eye, which was healing at this time. The father added

[3]This was also stated in police interviews with multiple agency employees after Matthew, Jr.'s death. Bruises were often observed on Burwood; when asked about them she would attribute them to interaction with London, but then minimize their importance or make excuses for London's actions.

[4]Several collaterals interviewed by police after Matthew, Jr.'s death made similar statements. They thought Burwood was afraid of London.

[5] The co-worker told police after Matthew, Jr.'s death that Burwood hadn't actually stated that London was jealous; this was her [co-worker's] opinion.

[6] Burwood told police after Matthew, Jr.'s death that London did this to strengthen the baby's arms.

> that both eyes ended up bruising. Along with the nose bruising (sic). He said the bruise along the nose was gone now, which R/O observed no bruising there. R/O did observe a very slight bruising under the left eye, and a bruised area under the right eye, with a small cut that looked as if it were healing. R/O also checked other areas on the child and found no other problems.

DCP met with the family the next morning. According to the DCP report, Burwood and London were interviewed separately on June 3; they were both cooperative and demonstrated affection and concern for their son. The injury to the baby had occurred while Burwood was at work; however, both parents told the CPI essentially the same story that the bruises happened accidentally. The CPI's notes state:

> I requested Mr. London show me exactly what had happened and we went into the bathroom. Mr. London displayed an infant tub which he placed inside the bathtub to show me how he was giving the baby a bath. Mr. London said he had shampoo in his son's hair and moisturizing baby bath soap on his body. He displayed a bottle containing both items. Mr. London showed me how he was sitting on the toilet, which is right next to the tub and was bent over the tub handling his son. He explained that he picked up Matthew and was trying to turn him over to wash his back. He was crying along with squirming and kicking when he slipped out of his hands and fell striking the faucet. Mr. London showed me that he was holding his son just above the faucet when he slipped. Mr. London said he immediately noticed the abrasion below his eye and a cut lip.

Both parents denied that London had "hog-tied" the baby. London explained that as a joke, he once tied the baby's arm to the crib slat with a bib and called Burwood in to look. London also confirmed the account given by Burwood's co-workers that the baby previously had bruises from a fall. London stated he set the baby on the bench of the booth in their trailer so that he could get a bottle; Matthew, Jr., only four months old, fell to the floor. London said he had not realized that the baby could not sit up by himself.

Burwood stated that London didn't keep her from seeing her son; sometimes when he got upset, he would take the baby into the back bedroom and play with him, but he didn't restrict her access to Matthew, Jr. Burwood denied being abused, but admitted that their relationship needed work.

Burwood's mother was interviewed. She told the CPI that she and her husband had always suspected that London was physically abusing their daughter. They did not believe their daughter's denials of physical abuse. Mrs. Burwood related that school personnel had told her that they had seen London push her daughter and boss her around. When Burwood was still living at home, her parents overheard London cussing and yelling at her over the phone. Once, Mrs. Burwood saw bruises on her daughter's chin; Burwood claimed that she fell and hit the steps at school.[7] Mrs. Burwood stated that she saw the baby once a week and had seen bruises on Matthew's face in the past. According to the CPI's notes:

> At the time, Matthew said he had put the baby on a booth in the trailer and he fell off. She said she didn't know what to believe. She said that when she sees

[7] Crown High School did not have a record of Burwood falling and injuring herself at school.

> Matthew with his son he appears to love the baby. Mrs. Burwood said he is very loving to the baby. She sees him hugging and kissing the baby all the time.

London's mother, Gwen Farmer, was interviewed by the CPI. Mrs. Farmer reported that she saw Matthew, Jr. five times per week. She told the CPI that her son brought the baby over in the evening while Burwood was at work. She had seen Matthew, Jr.'s bruised eye and a small cut. London told her he was giving the baby a bath and he wiggled and slipped out of his hands. Mrs. Farmer told her son and Burwood to take the baby to the emergency room, however, Burwood wanted to wait and take the baby to his pediatrician. Mrs. Farmer didn't remember the baby having any other injuries in the past. She thought the couple could benefit from services. She described the parents as being young and inexperienced and that they appeared overwhelmed at times. Mrs. Farmer said that she was a support system for them and both parents knew this. Mrs. Farmer was questioned about the parents' relationship. She said that they argued, but she denied knowledge of physical altercations.[8] Mrs. Farmer said she did not have concerns about the baby being abused, but she did feel they could benefit from therapeutic parenting classes.

The CPI told the OIG that most of the interviewees, particularly the relatives, could have been influenced by bias. His supervisor pointed out to the OIG that the biracial couple was living in a white community and that racial bias may have been a factor. The CPI believed the only person they could truly count on as being unbiased was Matthew, Jr.'s doctor. Burwood told DCP that she took Matthew, Jr. to his pediatrician, Dr. Montgomery, the day after the incident in the bathtub. The CPI called Dr. Montgomery who confirmed that he saw Matthew, Jr. on May 29, 1998. The CPI noted:

> He observed the baby with a minor bruise below his left eye and a cut upper lip with some swelling. The mother told him the injury occurred while the dad was giving him a bath in an infant tub. The father told her he picked up the baby and he slipped, falling and hitting something. The mother was not sure what the baby hit.... There were no other injuries noted and the explanation the mother provided could definitely be consistent with the injuries he observed. He had no information about the baby having another injury to his face as a result of a fall. He said the mother has displayed appropriate interactions with the baby[.] [H]e had seen the baby on 5/12/98 and 3/12/98 for checkups.

The CPI asked Burwood to take Matthew, Jr. back to Dr. Montgomery that afternoon, June 3, 1998. When the CPI called the doctor later, he recorded:

> He does not recall the minor bruise below the right eye being apparent when he saw the baby on the 29th and Ms. Burwood said the injury showed up right after he saw the baby on the 29th. Dr. Montgomery advised me the baby appeared to be fine and I talked with him about my plan to refer to the Progressions program and how that worked. He felt this was an appropriate plan and he agreed to keep a close eye on the baby when he sees him for future appointments.[9]

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[8] After Matthew, Jr. died, police asked Mrs. Farmer if she had knowledge of any physical altercations between the couple. She told them that she had seen Burwood strike London, but never the other way around.

[9] After Matthew, Jr. died, Dr. Montgomery called DCP. He stated that he still felt that the injury he saw could have been accounted for by the parents' explanation.

The CPI assessed the parents for criminal and substance abuse histories. He learned from the local police that London had one recent arrest. On May 2, 1998, he was arrested for possession of cannabis. The CPI completed adult substance abuse screens on both Burwood and London. London's arrest was the only sign of substance use.

Based on the information he gathered, the CPI concluded that there was insufficient evidence to indicate the report for cuts, welts and bruises caused by abuse or substantial risk of physical injury. He recorded in the family assessment that he was concerned about potential domestic violence in the home, and he was concerned for Matthew, Jr.'s safety, especially in light of the child's young age. He, therefore, indicated the report for cuts, welts and bruises due to neglect, based on the incident described by London where Matthew, Jr. had fallen from a bench before he was capable of sitting up by himself. In the Child Endangerment Risk Assessment Protocol (CERAP) dated June 4, 1998, the CPI recommended that:

> ...the parents be referred for counseling to deal with their relationship problems... the worker monitor the case by meeting with both parents to assess their abilities to provide for their son....the worker meet with the parents separately to assess the issue of domestic violence....the worker undress the baby to check him for injuries.

In his rationale for his disposition of the case, the CPI wrote:

> This is viewed as a high-risk case due to the age of the child and his parents. The child has been injured two times while in the care of his father. There are concerns about the possibility of domestic violence, which increases the risk.

Progressions Program

On the second day of his investigation, June 3, the CPI and his supervisor arranged for Intensive Family Preservation Services (IFPS) through Progressions Family Services. The CPI's supervisor told the OIG that they felt these services were appropriate because the program would begin to work with the family immediately, they could work with the father who lacked parenting skills, and because Progressions makes unscheduled visits, they could monitor and assess violence in the home.

Progressions is an intensive family preservation service based on the Homebuilders model. All Progressions clients have been the subject of an indicated report of child abuse or neglect. The primary intent of intensive family preservation services is to prevent removal of children from the home. The Progressions contract reads:

> The Family Preservation Initiative is designed to improve and to expand services to abusive or neglectful families on five fronts: emergency response; risk assessment and case planning; comprehensive assessment of the family's problems, strengths and needs; the capacity to provide services based on need; and the inclusion of community resources as part of a comprehensive range of services available to referred families.

Progressions' program provides intensive services for nine to twelve weeks. Therapists are on call for families 24 hours per day, seven days per week. Progressions expects its therapists to see

their families at least three times per week. The children in the family are seen at least once per week.

Progressions' therapists are required to have an MSW and one year of social service experience, or a masters in a human services related field and two years of experience. At the time that the therapist, Gregory Yellen, was assigned to the Burwood-London family, he met the requirements.[10] Progressions therapists have small caseloads, usually three cases. Mr. Yellen stated that he was carrying four cases during the time he was working with this family.

Progressions' contract outlines that services provided will be both hard and soft. Hard services include assistance in obtaining basic necessities (e.g., food, housing, clothing, child care, employment). Soft services are counseling to help clients change their behavior, and referrals for other needed services (e.g., substance abuse assessments, domestic violence services).

Progressions' contract with DCFS states that the program is to accept cases referred to them by DCP, that meet contractual criteria, on a no decline policy unless they are full. For all referrals, the safety of the children should be reasonably assured at the level of intensity of services to be offered. The criteria for accepting referrals in order of priority are as follows:

1. Families who meet the criteria for services as required by the Norman Consent Decree.
2. Families who are the subject of a priority one-abuse or neglect report/investigation and at least one child age 12 years or under is an involved child subject of a report, and placement of a child is imminent.
3. Families who are indicated priority two cases with three or fewer indicated reports, where one or more children age 12 or under are at serious risk of harm.
4. Subjects of a current report with more than three previously indicated investigations of abuse or neglect may be referred when the Department believes the family can benefit from the intensive in-home intervention. DCP priority one cases will be referred first; priority two cases will be referred second.
5. Open cases when the child protection supervisor and the follow-up supervisor concur on the referral or as approved by Regional Progressions Coordinators. The case has been active for 18 months or less and either a subsequent oral report has occurred within 7 days of the referral, or the Department has custody or guardianship with the right to place.
6. Cases can be referred solely for assessment of presenting problems, service needs and recommendations.

The Progressions contract excludes five types of cases:

1. Families where an indicated death for abuse/neglect to a sibling has occurred will be excluded unless the perpetrator is out of the home.
2. Parents with a history of or a current diagnosis of a serious psychiatric illness who have had psychiatric hospitalizations and whose mental health is not successfully stabilized by psychotropic drugs. This exclusion includes parents who undergo cyclic remissions, followed by periods of behavior in which they are a danger to themselves or others.

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[10] Gregory Yellen has a Master's degree in Psychology. He had 22 months of social service experience when he was assigned this case. He had 13 months of social service experience when he was hired.

3. If sexual abuse is involved the family shall not be served unless the perpetrator is not residing in the family home, or the Department has firm cause to believe that the perpetrator can be convinced or compelled to leave the home, or the Department has firm cause to believe that the abuse will not be repeated while services are offered.
4. The primary caretaker is a substance abuser who refuses treatment.
5. The level of risk to the child(ren) cannot be reduced through intensive services.

The day after the hotline call, on June 3, the CPI met with Progressions therapist Gregory Yellen to discuss the case. The CPI told the OIG that he told the therapist everything he knew about the case. In addition, Progressions received a complete copy of the DCP investigation. There was a staffing between DCP and Progressions regarding the case. The Progressions supervisor, Aaron Gentry's notes from the staffing indicated, "Mitchell [CPI] states that Donna's mom reports that she believes that Donna has been victim of domestic violence by [Matthew]" and in the case referral form Gentry noted, "Some talk about d.v. – People around have said mother has been seen with bruises."

On June 5, Gregory Yellen made his first visit to begin discussing safety for the baby. The Progressions therapist attempted ten visits between June 3 and June 23. On six of the ten visits someone was at home. On the first three occasions both parents and the baby were present. On two occasions the father and the baby were present. On the remaining and last occasion, only the father was present.

Burwood and London had not yet signed a service plan. The supervisor, Gentry, told the OIG that service plans are usually signed the twentieth day of service. The Progressions therapist had prepared one, which both he and his supervisor had signed. London reviewed it on June 23; however, he said he wanted to wait for Burwood to see it before signing. The service plan included:

- Clients will list, with therapist's assistance, behavioral expectations for children of particular ages/developmental levels;
- Therapist and client will review growth developmental guidelines for Matthew, Jr.; therapist will teach communication strategies; clients agree to practice communication strategies presented to them by therapist;
- Clients agree to implement safety measures to minimize environmental risks to child; clients agree to allow therapist to view child;
- Therapist agrees to present information about safety factors pertinent to Matthew, Jr.;
- Therapist agrees to provide clients with a home safety checklist;
- Clients agree to have child attend therapeutic day care;
- Matthew Sr. agrees to participate in therapeutic day care for a half day on a weekly basis;
- Therapist agrees to arrange therapeutic day care.

Mrs. Burwood reported to the OIG that in the weeks before Matthew, Jr.'s death, she called DCP more than once to report bruises on Matthew, Jr.[11] CPI Clark told the OIG that Mrs. Burwood called him once after his investigation was closed saying that she "thought" she saw bruises.

[11] She could not remember exactly when she called.

Clark referred her to both SCR and the therapist. Mrs. Burwood did not call SCR but did call Progressions. Mrs. Burwood told the OIG that she called Progressions multiple times and talked to several people attempting to report bruises she saw on Matthew, Jr. The therapist recorded a telephone call from Mrs. Burwood on June 22, at 4:20 p.m. Mrs. Burwood reported that on June 19 she had seen two palm sized bruises on Matthew, Jr.'s abdomen and back and a scrape on his forehead.[12]

The therapist's notes indicate that ten minutes after he received Mrs. Burwood's call, he consulted with his supervisor. They decided the therapist should make an unscheduled visit to see the child. Progressions had not seen Matthew, Jr. since June 15, seven days earlier. The family was not home for a scheduled visit on June 17, no one was home for an unscheduled visit on June 19, and on June 20 London canceled a visit scheduled for June 22. At 6:00 p.m. on June 22, the therapist arrived at the Burwood-London residence. London answered the door. Matthew, Jr. was lying on a blanket on the floor of the living room. After observing the baby, the therapist determined that Matthew, Jr. was alert and responsive. He asked the father to undress the baby. The therapist told the OIG that Matthew, Jr. was wearing a sleeveless, legless outfit and London initially just showed him the baby. The therapist told the OIG that London was irritated at having to fully unclothe Matthew, Jr. The therapist recorded that he observed a scab on the baby's forehead and a "nearly healed bruise," 2" by 1" on the baby's back. He did not record in his June 22 notes that he asked London about the cause of the baby's marks.

The therapist told the OIG that the bruise was quite faint. He was not really sure what he was seeing because it looked like a discoloration. He stated that he had never had training in how to identify marks that could be from abuse in contrast to marks that could be normal. He said he considered that the mark on Matthew, Jr.'s back could be just from picking him up.

After this visit, the therapist recorded that he again consulted with his supervisor. The supervisor told the OIG that when he talked to the therapist that night, the therapist reported seeing a small scrape on Matthew, Jr.'s forehead and discoloration on the baby's back, but that he was not sure what he was seeing. The supervisor opined that there was nothing to warrant a hotline call. His judgment was based, in part, on his hesitancy to accept Mrs. Burwood's report of bruises because of his suspicion that she was biased against London. He said she had told the therapist that she "hated" London.[13] The therapist stated that he was uneasy with this decision, but he understood that it was his supervisor's call.

The supervisor decided the next morning, June 23, after a staffing, that the hotline should be alerted. The therapist told the CPI investigating Matthew, Jr.'s death that when they reconsidered the situation with other staff, they realized a bruise on that part of the body of a five-month-old infant could not be an accident. The supervisor advised the therapist to ask Mrs. Burwood to call the hotline. The supervisor told the OIG that his reasoning was that it would be more likely that

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12 This was the only telephone call recorded by Progressions. Burwood was adamant that she made several calls to both DCP and Progressions to report bruises. Mrs. Burwood said that she saw the bruises on June 19. In all likelihood, she would have tried to report them on that day. Yet, the first documented contact with Progressions was three days later, on June 22. The therapist told CPI Royster after Matthew, Jr.'s death that he had had multiple conversations with Mrs. Burwood in which she stated that she "hated" London. These conversations had not been documented by the therapist.

13 This was not documented in the Progressions therapist's notes. However, the therapist reported to police and DCP after Matthew, Jr.'s death that Mrs. Burwood had told him that she hated London.

the hotline would accept a call from the maternal grandmother who had been the primary witness four days earlier, than from a secondary witness who saw only faint markings.[14] The supervisor told the OIG that, in the past, he had made hotline calls that were not accepted. In his notes, the therapist recorded that he planned to ask Mrs. Burwood to call the hotline and if she would not, he would.

The therapist told the OIG he was upset with his supervisor during this staffing because he had gotten "mixed messages". While the supervisor had told him not to call the hotline the night before, the supervisor intimated at the staffing that the therapist should have called. Two other therapists present at the staffing stated that they would have called the hotline. The therapist told the OIG that he had had no training in determining when to make a hotline call and had been relying on his supervisor for guidance and instruction.

At 11:30 a.m., the Progressions therapist recorded that he placed a call to Mrs. Burwood, but she was not home. It took over an hour for the therapist to find someone who could give him her work number. Finally, at 12:50 p.m., he reached Mrs. Burwood while en route to a previously scheduled visit at the Burwood-London residence; she asked him to be the one to call the hotline.[15]

At 1:15 p.m., the therapist and an Outreach worker, Robin Bradley, arrived for the scheduled visit. The Outreach worker was to talk about child development and discuss a safety plan for the home (e.g., keeping electric cords out of reach). They talked only to London who reported that Burwood had to take the car in for repair and that Matthew, Jr. was sleeping in the other room. The therapist presented a home safety checklist and discussed therapeutic daycare.[16] He asked London, for the first time, about the bruise he had seen on Matthew, Jr. the day before. He recorded in his notes that London denied being aware of a bruise on Matthew, Jr.'s back.

The Progressions Outreach worker told the OIG that she was not made aware of domestic violence concerns about this family. She also said that she did not know that the maternal grandmother had called the therapist about seeing bruises on Matthew, Jr. and that the therapist had been to the house to check the child the day before. Neither the therapist nor the Outreach worker saw Matthew, Jr. during this June 23rd visit.

After the visit, at 4:00 p.m., the therapist called the hotline. A hotline worker, Rochelle Anderson, returned his call at 4:54 p.m. Anderson told the Progressions therapist that someone from DCP would go out in the morning. Unfortunately, it was too late. London called 911 at 5:49 p.m. Matthew, Jr. was taken to the hospital and pronounced dead on arrival at 6:09 p.m. He

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[14]CPI Royster recorded that the Progressions therapist stated that the reason Mrs. Burwood was asked to call the hotline was because she had seen bruises on both Matthew's back and abdomen, while he had only witnessed one bruise on his back.

[15]Vivian Burwood told the OIG that she was confused by the Progressions therapist's request to make the call. She felt that Progressions staff were the experts and as social workers they should have known how to best handle the situation.

[16]The Progressions therapist "discussed the advisability of therapeutic daycare" at a staffing on June 17 with his supervisor, the CPI and the CPI's supervisor. The therapist told the OIG that therapeutic daycare services require the parent to come in with the child four hours per week. Experts then assess parent-child interaction. The therapist stated that he wanted to get someone with more training to assess the parent-child interaction between London and his son.

had bruises on his abdomen, back, left leg, left cheek and forehead. The Fullham county coroner determined that Matthew, Jr. died from blunt trauma to the abdomen with blunt trauma to the head being a contributing factor. A coroner's jury ruled that the baby's death was a homicide.

The events of the day of Matthew London, Jr.'s death, June 23, 1998, are summarized in Appendix B. A chronology of the case is presented in Appendix C.

ANALYSIS

The events of this case unfolded in a very short period of time. Only 21 days passed from the time of the initial hotline call, June 2, 1998, to the date of Matthew London Jr.'s death, June 23, 1998.

DCP Investigation

Overall, CPI Mitchell Clark completed a skilled investigation. In hindsight one might think of further investigative activities the CPI could have undertaken. For example, the CPI could have informed Matthew, Jr.'s pediatrician about the reports of bruises on Donna Burwood and the suspicion of domestic violence between Burwood and London. With this information, the doctor might have reconsidered the cause of the infant's bruises. Given his suspicion of domestic violence, the CPI could have called local hospitals to inquire if Burwood had visited the ER in the last year with suspicious injuries. However, this search would have proven fruitless.[17] The CPI did, however, intuitively recognize the high risk to the child in this family; so, to intervene, he indicated the investigation for neglect. The CPI's referral to Progressions was a sound one given that the evidence of risk, at that time, did not rise to the level necessary for taking protective custody as cited in DCFS Rule and Procedure 300.120:

> The investigative worker.... must have reason to believe that leaving the child in the home or in the care and custody of the child's caregiver presents an imminent danger to the child's life or health...[and] in-home services would not sufficiently protect the child from life-threatening or severe physical injury.

The CPI should have acted proactively, however, when Mrs. Burwood called him, after the completion of his investigation, to report that she was concerned because she had seen bruises on Matthew, Jr. Instead of calling the hotline himself or making a joint call with Mrs. Burwood, the CPI told Mrs. Burwood to contact the Progressions therapist and/or SCR. DCP Manager Darrell Sims defended Clark's lack of action by asserting that the CPI's investigation was closed and he had no more responsibility for the case.[18] While this was technically true, good practice dictates a more common sense, proactive response. In addition, the CPI is a mandated reporter, and should have responded as directed by the Abuse and Neglect Child Reporting Act (ANCRA) and DCFS Rule 300.30 (Reporting Child Abuse or Neglect to the Department):

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[17] The OIG called all area hospitals. There were no admissions to the ER for Donna Burwood in either 1997 or 1998.

[18] In an attempt to prevent similar errors in the future DCFS initiated Policy Transmittal 99.24 which requires that "reports of abuse or neglect taken at local offices when a caller contacts the assigned child welfare caseworker of an open service case or the child protective investigator of pending or previously indicated or unfounded report sequence and provides information that constitutes a new report."

> [Persons] who have reasonable cause to believe that a child known to them in their professional or official capacity may be abused or neglected shall immediately report or cause a report to be made to the Department.

In this situation, the CPI was aware of two prior occurrences of bruises on this 5-month old baby who was living in a potentially violent environment. While it made sense to refer the grandmother to the professionals working with the family, the possibility of a third instance also gave the CPI reasonable cause to contact the hotline.

Progressions Program

Because the CPI did not have enough evidence to indicate for abuse and justify removing Matthew Jr. from his home, he instead indicated for neglect and attempted to arrange for the provision of the highest level of monitoring available among the Department's intact family programs. Arguably, intensive family preservation services provide the highest level of safety for children short of removing them from their home.

When the CPI referred the London family to Progressions' program, he shared his concerns about the family to the Progressions staff and forwarded the DCP investigative file, which Progressions was obligated to read. The complete investigative file contained interview notes documenting risk, and clearly articulating the CPI's assessment of: (1) the high-risk nature of the case, (2) the need to assess domestic violence in the home, (3) the need to check the baby for injuries. Progressions staff should have understood from their discussions with the CPI and from the investigation report that, there were strong concerns for the infant's safety because of the young age of the parents, the child's age, the existence of two injuries to the infant while in the care of his father, and suspected domestic violence – so that while the case was indicated for neglect, neglect was not the underlying issue. Unfortunately, Progressions' staff did very little by way of immediate linkage to services based on what they knew from the DCP investigation.

Progressions' involvement and assessment was inconsistent with that of DCP; Progressions rated the Burwood-London case as only moderate risk, giving the appearance that the Progressions staff may not have carefully read the DCP report nor listened to the CPI's findings and concerns. As a result, Progressions did not correctly assess the family nor provide comprehensive case management.

The Progressions supervisor stressed in his interview with the OIG that the Burwood-London case was a neglect case and the purpose of the Progressions intervention with this family was to educate these young and inexperienced parents. His view was echoed by the limited tasks outlined in the family's service plan. While parenting education was one valid goal of service, in the Burwood-London case it was insufficient alone. Based on the information contained in the DCP report, Progressions should have concurrently devised ways to assess and limit the risk of harm to Matthew, Jr. and made efforts to assess the household for domestic violence.

Progressions allowed Matthew, Jr. to remain vulnerable in the care of his father without putting in place any protective services that may have reduced the risk to Matthew, Jr. Both of the infant's injuries occurred while he was alone with London. Although there was no direct evidence that he had abused Matthew, Jr., London had not demonstrated the ability to protect his son from harm while in his care. Thus, Progressions should have taken immediate steps to eliminate or reduce the time that London was alone with the baby. There were realistic resources to help decrease the time London and Matthew, Jr. were isolated. One option was protective day

care. Another option was extended family members. Both grandmothers exhibited strong interest in the welfare of their grandson. Mrs. Burwood stated that she saw Matthew, Jr. weekly. London's mother, Mrs. Farmer, said that she saw him several times per week. Progressions could have convened a family meeting to make a protective plan for the baby. It is likely that the grandparents would have willingly accepted responsibility to provide joint or respite care for Matthew, Jr. and watch carefully for signs of injury to him. The plan could have designated steps to take if an injury were suspected. Mrs. Farmer, in particular, would have been an excellent resource to build upon. She caused London less stress than Mrs. Burwood given the history of tension between London and his girlfriend's family. Installing these protections for Matthew, Jr. also could have provided time to either rule out or establish the existence of domestic violence and/or child abuse in the home, and may also have had a deterrent effect.

Progressions failed to take steps to confirm or disprove domestic violence between Burwood and London. There is a nexus between domestic violence and child abuse. In homes where abuse occurs among partners, children are at a substantially greater risk of abuse by both the perpetrator and the victim.[19] There was a strong suspicion of domestic violence in this case. It was reported across two settings: home (Burwood's mother) and work (Burwood's co-workers); thereby establishing greater reliability of the reports. The need for a domestic violence assessment was established by the information contained in the DCP investigation. Establishing the existence of domestic violence in the home would have substantiated increased risk of harm to Matthew, Jr., thereby creating options to provide greater protection for him. Progressions would have had the leverage to engage Burwood and London in domestic violence services while allowing Matthew, Jr. to stay with a relative either voluntarily or by court order. Ignoring this significant risk factor was negligent on the part of Progressions. The Progressions contract lists examples of reimbursable services available to families enrolled including "domestic violence services" *(4.2)*. Progressions should have referred London and Burwood for a domestic violence assessment. A DHS approved domestic violence service provider was available in the community. Yet, the need for a domestic violence assessment was not discussed with the couple and this task was not included in the service plan developed by the Progressions therapist and his supervisor.

To provide comprehensive services, the Progressions therapist needed to accurately assess his clients. Greater attention should have been given to the personal circumstances of each parent. London desperately needed individual attention. This young father had been a community football hero. But in the summer of 1998, he was trapped. He was an eighteen-year-old unemployed "babysitter", without a high school degree, living in a cramped trailer, and relying on his girlfriend and her disapproving parents for financial support. Emotions of frustration, anger, and depression would have been reasonable reactions to these circumstances. Each would have contributed to tension in the home and the potential for abuse to the only thing London had under his full control - Matthew, Jr. Progressions should have recognized the need to assist London in alleviating some of the stress inherent in his situation. Day care, employment, education, vocational training, and individual counseling all could have offered London some hope and opportunity, and consequently diffuse some of the tension in the home. However, neither the Progressions therapist nor supervisor included these interventions in the service plan developed for London and Burwood.

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[19] Carter J, Schechter S., (1997, November) Child Abuse and Domestic Violence: Creating Community Partnerships For Safe Families *Child Family Violence Prevention Fund.*

Burwood also could have benefited from some individual attention. At the very least, the Progressions therapist should have met individually with Burwood to elicit her opinion regarding what services her family could benefit from and to give her the opportunity to reveal any concerns she might have about London or his care of Matthew, Jr. In eliciting her input, the therapist might have also begun to develop a rapport with Burwood and thereby increase the opportunity that she might eventually disclose her vulnerability in the home.

The main service that Progressions committed to providing - frequent visitation – did not protect Matthew, Jr. The Progressions therapist was in the Burwood-London home earlier on June 23, the day Matthew, Jr. died. He did not ask to see the baby when London said that Matthew, Jr. was asleep in his bedroom. According to both the Progressions therapist and his supervisor, the therapist did not view Matthew, Jr. during this visit because he had seen him the day before and the therapist did not want to appear intrusive to London. The therapist said he did not want to get London upset and then leave him alone with Matthew, Jr. The Progressions therapist's concern about being intrusive illustrates a discomfort with his role in providing child protection. Although Progressions workers must work to build an alliance with adult clients, concern for maintaining such an alliance should not supersede child protection; intrusiveness may be necessary. If the Progressions therapist was this fearful for Matthew, Jr., it amounted to a reasonable suspicion of abuse and, he was required to take immediate action. Both the Progressions therapist and the supervisor failed to recognize the potential immediacy of the risk of harm.

Progressions should have established a rule on day one of service that Progressions staff would unclothe and view Matthew, Jr. on every visit, whether scheduled or unscheduled, to check for any signs of injury on the infant. If this rule had been followed at every visit, then London would have expected such inspections. The Progressions therapist could have avoided the discomfort of having to ask to see the child, could have more easily identified unusual marks, and would have had greater confidence in calling SCR. Regular inspections of Matthew, Jr. might also have provided deterrence for the father, in that it would be more difficult to hide injuries to the infant.

Regardless of whether a frequent inspection practice had been established, the Progressions therapist should have asked to see Matthew, Jr. on June 23 for several reasons. First, when asked on this date about the bruise on Matthew, Jr.'s back, London denied being aware of it. The therapist could have pointed out the bruise and asked London again for an explanation. Second, the therapist was going to contact the hotline about the bruise following the visit. By viewing the baby a second time, he could have refreshed his recollection of the bruise and checked for any new marks to be added to the report. Finally, and most importantly, the Progressions therapist needed to ensure Matthew, Jr. had no additional injuries.

Like the CPI who received a call from Mrs. Burwood reporting bruises on Matthew, Jr., the Progressions therapist should have contacted the hotline immediately after receiving Mrs. Burwood's call on June 22. The Progressions therapist is a mandated reporter. Mrs. Burwood informed him of specific marks and bruises (two palm-sized bruises on the abdomen and back and a scrape on the forehead) that she saw on June 19.[20] Contrary to the Progressions

[20] It took three days for Mrs. Burwood to reach the Progressions therapist to voice her concern. If she had been involved in making a protective plan for Matthew, Jr., she would have known how to reach the therapist and what steps to take if she suspected an injury. This may have led to a quicker response for Matthew, Jr.

supervisor's belief, it was not necessary for the grandmother to contact the hotline herself because she was the primary witness. The hotline would have indicated on the CANTS 1 that Mrs. Burwood was the "source of the report" and DCP would have interviewed her in addition to the Progressions therapist.

Mrs. Burwood reported that she saw the bruises on June 19. The Progressions therapist had last seen Matthew, Jr. on June 15. The family was not home for a scheduled visit on June 17 or an unscheduled visit on June 19. On June 20 London canceled a visit scheduled for June 22 (it was rescheduled for June 23). Thus, on June 22 when Mrs. Burwood spoke to the Progressions therapist, he had not seen the baby in a week, despite his attempts to visit. When a case has come to a service provider's attention because of prior injuries, or there is a suspicion of current injury, a family's unavailability for visits should be viewed as possible attempts by the family to avoid detection of injury. London's unavailability in conjunction with Mrs. Burwood's allegations of harm should have raised the Progressions supervisor's level of concern to the point of immediately contacting the hotline.

Instead, the Progressions supervisor told the Progressions therapist to make an unscheduled visit to see Matthew, Jr. The Progressions therapist viewed Matthew, Jr. and observed two of the three marks Mrs. Burwood had reported seeing three days earlier – a scrape on his forehead and a bruise on his back. The Progressions therapist contacted his supervisor to report seeing these marks, but stated that he was not sure about what he was seeing. The Progressions supervisor decided a hotline call was not warranted. This decision was based, in part, on his suspicion that Mrs. Burwood was biased against London. Thus, the supervisor's own bias against Mrs. Burwood clouded his judgment in deciding whether the hotline should be contacted. While Mrs. Burwood's report of bruises alone would have justified a hotline report, the following safety and risk factors were present at the time:

- Teen parents;
- Age of the child;
- Unresolved reports of domestic violence; bruises reported on mother across settings;
- Father's vulnerable circumstances: loss of status and opportunity in football, unemployment, lack of a High School Degree, isolation, financial dependence on Burwood;
- Two prior reports of bruises to an infant less than four months old
- Missed/canceled/rescheduled visits over past week
- Same marks/bruises witnessed by grandmother and Progressions therapist.

The Progressions supervisor was aware of the risk factors (the family had been given a high risk rating by the agency) in the case all along and never impressed upon the novice therapist the critical need to monitor for all signs of risk of harm. The Progressions supervisor told the OIG Investigator that Progressions procedures require therapists to contact their supervisors immediately when there is risk of harm to a child. The supervisor did not sense any urgent need to remove the child from his father's care. But most egregious, as a mandated reporter, he advised not calling the hotline and failed to assist Mrs. Burwood in making such a call. Thus, Progressions did not respond appropriately when an emergency presented itself.

The Burwood-London case was assigned to Gregory Yellen because he was the next in line for a new case. The Progressions therapist complained to the OIG Investigator that he didn't have the

preparation he needed to do a good job in this case. He had no training in dealing with domestic violence, recognizing signs of child abuse, or deciding when to make a hotline report. At the time he received the Burwood-London case, the Progressions therapist had been employed by Progressions for only nine months. He had no previous experience in child welfare.

RECOMMENDATIONS

1. In a May, 8, 1998, memo to the Director regarding an OIG report, the OIG proposed that DCFS more clearly define criteria for cases that are appropriate for Progressions or Intensive Family Preservation Services (IFPS). The screening criteria for all Intensive Family Preservation Services programs should be refined to ensure that only cases in which the following two questions can be answered in the affirmative would be accepted:

   1) Is the identified problem(s) likely to be corrected (or assessed) within 28 days?
   2) Can the safety of the child(ren) be reasonably assured during the 28 days?

   Protective measures that could be taken to "reasonably assure" the safety of the children during the 28 days should be specified. These should include protective day care and extended family protective care taking plans.

   The OIG continues to recommend that the criteria be more clearly defined and that the above recommendation be implemented.

2. The Department of Human Services (DHS) has a detailed and well-grounded protocol for working with families for whom domestic violence is an issue. DCFS should adopt the DHS protocol for working with families for whom domestic violence is a factor.

3. ***This recommendation addresses discipline and has been redacted.***

4. ***This recommendation addresses discipline and has been redacted***

5. The Executive Director and the Board of Directors for Progressions should receive a copy of this report and conduct an internal review of the case. The Inspector General will meet with the Executive Director and Board to discuss the findings and recommendations of this report.

APPENDIX A

	Date	Visit	Met with
	June 3 3:00pm	CPI introduces Progressions therapist to the Burwood-London family; therapist schedules meeting with family at their home for June 5.	CPI, Progressions therapist, Burwood, London, Matthew, Jr.
	June 5 10:30am	Progressions therapist makes **scheduled visit**: discuss safety precautions to keep infant from falling; schedule next visit for June 8.	Progressions therapist, Burwood, London, Matthew, Jr.
	June 8 10:30am	Progressions therapist makes **scheduled visit**: view video, "Somebody Loves Me." Discuss safety, daycare, individual and couples counseling. Arrange next visit for June 10.	Progressions therapist, Burwood, London, Matthew, Jr.
	June 10 6:30pm	Progressions therapist and outreach worker arrive for **scheduled visit**. No one home. Leaves note asking to reschedule - calls to reschedule on June 11.	X
	June 12 3:55pm	Progressions therapist makes **unscheduled visit**. No one home. Leaves note - on June 13, calls Burwood-London residence and reschedules appointment with Burwood for June 16 (or 15).	X
	June 15 (or 16) 9:30am	Progressions therapist makes **scheduled visit**. London tells therapist that Burwood is not present because she has to work. Discuss appropriate expectations for child development. Schedules two meetings June 17 & 22.	Progressions therapist, London, Matthew, Jr.
	June 17 3:00pm	Progressions therapist makes **scheduled visit**. No one home. Leaves note.	X
	June 19 3:15pm	Progressions therapist makes **unscheduled visit**. No one home. Leaves note.	X
	June 22 6:00pm	On June 20, London called to cancel a scheduled visit for this day. Progressions therapist returned London's call and rescheduled for June 23. However, Progressions therapist makes **unscheduled visit** to check Matthew, Jr. for injury after call from MGM. Sees discoloration, looks like bruise in state of healing on back and scab on forehead.	Progressions therapist, London, Matthew, Jr.
	June 23 1:15pm	Progressions therapist makes **scheduled visit**. Discuss child development, therapeutic daycare, and the bruise. Schedule visit for June 26.	Progressions therapist, Progressions outreach worker, London
Total	20days	Ten attempted contacts.	Six actual meetings. Three with all family members present.

APPENDIX B

6/23/98	11:10am	Progressions therapist discusses observed bruise with his supervisor and two other Progressions therapists. The therapist says that he will encourage the MGM to call the hotline and if she will not do it, he will.
	11:35am	Progressions therapist calls MGM residence; no one at home.
	11:38am	Progressions therapist calls CPI to try to get MGM work phone; CPI not in.
	12:45pm	Progressions therapist calls MGM residence; male answers the phone and gives work number.
	12:48pm	Progressions therapist receives a call from London saying that Burwood would not be able to meet with therapist today before work because the muffler fell off her car; she went to repair the car. Therapist states that he and an Outreach worker will be out at the residence in one-half hour.
	12:50pm	Progressions therapist calls MGM at work while en route to Burwood-London residence. They discuss calling the hotline. MGM asks therapist to do it. Therapist tells MGM in the future to call the hotline or he as soon as she sees any marks on the baby.
	1:15pm – 2:45pm	Progressions therapist and Outreach worker visit London. They review a safety checklist; London reports that Matthew, Jr. is sleeping in his bedroom. Therapist discusses child development of infants, therapeutic daycare, and, finally, the bruise observed on Matthew, Jr.'s back the night before. London denies awareness of any bruise. Scheduled next visit for 6/26/98 at 1:00 pm; therapist was to be accompanied by his supervisor.
	4:00pm	Progressions therapist calls the hotline.
	4:54pm	Hotline worker returns therapist's call. Progressions therapist reports what MGM told him, what he observed, and what the father's response was. Hotline worker tells therapist that DCP will go out in the morning.
	8:45pm	Progressions therapist pages supervisor to tell him there is a message from the DCP supervisor on the Progressions' answering machine about the death of a baby.
	9:20pm	Progressions supervisor calls therapist. Baby who died was Matthew, Jr. He died late in the afternoon. London claimed that he left Matthew, Jr. with an aunt while he was at work. Therapist tells supervisor that they had discussed employment that afternoon. Therapist and Outreach worker had left the home about 2:45pm.

APPENDIX C

Chronology of the Case

Date	Time	Event
6/2/98	1:29pm	Co-workers of Burwood call the hotline CPI opens investigation.
6/3/98	3:00pm	CPI meets with Progressions therapist to discuss case. CPI and Progressions therapist visit London & Burwood to hand off the case. Therapist reviews agency agreement with parents. Scheduled next visit for June 5, 1998.
6/5/98	10:30am	Progressions therapist visits London-Burwood home. Both parents and baby are present. Attempts to show video "I Love Somebody" tape fails. Discusses safety precautions to keep child from falling. Next visit scheduled for 6/8/98 at 10:30am.
6/8/98	10:30am	Progressions therapist visits London-Burwood home. Both parents and baby are present. Played home safety video "I Love Somebody" Discussed safety: not leaving child unattended in the bathtub, monitoring the temperature of bath water, shaking baby, precautions that will be needed when Matthew, Jr. starts crawling. Offered daycare and individual and couples counseling for London and Burwood. Set next meeting for 6/10/98 6:30pm. (Therapist couldn't meet during the day because of a mandatory Progressions retreat) Burwood had to work during that time.
6/9/98	9:20am	Voice mail for Progressions therapist from CPI
	1:15pm	Vivian Burwood (MGM) called CPI to say she was afraid that London was abusing Burwood and that she was welcome to come home.
6/10/98	6:30pm	Progressions therapist and Outreach worker arrive at London-Burwood residence. No one is home. Left at note asking London to call to reschedule appointment.
6/11/98	4:15pm	Progressions therapist leaves phone message asking London-Burwood to reschedule appointment.
6/12/98	3:55pm	Progressions therapist makes unscheduled visit to London-Burwood trailer. No one at home. Left a message asking to schedule another appointment.
6/13/98	10:00am	Progressions therapist calls and is able to schedule an appointment for 6/16/98 at 9:30am.
6/15/98	9:30am	Progressions therapist makes visit. Only London and Matthew, Jr. are home. Burwood at work. London says he forgot about the last appointment on 6/10/98. London states that his mother and sister assist with childcare for Matthew, Jr. They discuss appropriate expectations for child development at five months. Two meeting scheduled, one with supervisor, The supervisor on 6/22/98 and next regular meeting on 6/17/98.
6/17/98	1:30pm	Progressions therapist, supervisor, Clark, and Mayhew conduct staffing about case. Mention missed meeting and failure of London & Burwood to contact therapist to reschedule. Discuss objective of further education for parents about learning appropriate expectation of the baby, minimizing risk and developing communication between parents. Also discussed therapeutic day care.
	3:00pm	Progressions therapist goes to visit but no one at home. Left a note asking couple to call and reschedule the appointment.

6/19/98	3:15pm	Progressions therapist makes unscheduled visit to home. No one at home. Left a note asking the couple to contact him to schedule an appointment.
6/21/98	8:00pm	London calls to cancel 6/22/98 visit.
6/22/98	12:40pm	Progressions therapist calls and talks to Burwood. Makes an appointment for 6/23/98 at 1:15; Burwood has to leave for work at 1:30. Therapist says he will try to come early.
	4:20pm	Vivian Burwood (MGM) calls Progressions therapist. She says she saw palm sized bruises on Matthew, Jr.'s abdomen and back as well as a scab on his forehead on 6/19/98.
	4:32pm	Progressions therapist consults w/supervisor. They decide that therapist should make an unscheduled visit and undress the baby to look for evidence of bruises.
	6:00pm	Progressions therapist observed Matthew, Jr. to be alert and reactive. He had a scab on his forehead and discoloration 1" by 2" on his back that appeared to be a bruise in a state of near healing.
	7:00pm	Progressions therapist pages supervisor. The supervisor calls back; therapist tells him about the discoloration on Matthew, Jr.'s back and that it is faint. They discussed calling the hotline. Resolution not noted
6/23/98	11:10am	Progressions therapist discusses observed bruise w/supervisor, Arlene Berry (Progressions therapist) and Dave Gomer (Progressions therapist). Therapist says that he will encourage the MGM to call the hotline and if she will not do it, he will.
	11:35am	Progressions therapist calls MGM residence; no one at home.
	11:38am	Progressions therapist calls CPI to try to get MGM work phone; CPI not in.
	12:45pm	Progressions therapist calls MGM residence; male answers the phone and give work number.
	12:48pm	Progressions therapist receives a call from London saying that Burwood would not be able to meet with therapist today before work because the muffler fell off her car; she went to repair the car. Therapist states that he and Outreach worker will be out at the residence in one-half hour.
	12:50pm	Progressions therapist calls MGM at work on his cellular phone en route to Burwood-London residence. They discuss calling the hotline. MGM asks therapist to do it. Therapist tells MGM in the future to call the hotline or he as soon as she sees any marks on the baby.
	1:15pm	Progressions therapist and Outreach worker visit London. They review a safety checklist; London reports that Matthew, Jr. was sleeping in his bedroom. Therapist discusses child development of infants and discusses therapeutic daycare, and finally the bruise observed on Matthew, Jr.'s back the night before. London denies awareness of any bruise. Scheduled next visit for 6/26/98 at 1:00pm; therapist was to be accompanied by the supervisor.
	4:00pm	Progressions therapist calls the hotline.
	4:54pm	Hotline worker Rochelle Anderson returns his call. Progressions therapist reports what MGM told him and what he observed and father's response. Anderson tells therapist that someone will go out in the morning.
	8:45pm	Progressions therapist pages supervisor to tell him there is a message from Mayhew on the Progressions answering machine about the death of a baby.

	9:20pm	The Progressions supervisor calls therapist; baby who has died was Matthew, Jr. He died late in the afternoon. London claimed that he left Matthew, Jr. w/ an aunt while he was at work. Therapist tells supervisor that they had discussed employment that afternoon. Therapist and the Outreach worker had left the home about 2:45pm.

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

OLDER CAREGIVER/FIVE PLUS CHILDREN: PROBLEM-SOLVING SERVICE MODEL

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EXECUTIVE SUMMARY

Between 1986 and 1997 Illinois experienced a significant increase in the number of children requiring foster care.[1] To meet the demand for foster care placements, family relatives were asked to provide foster care. Now, more than half of the children in foster care reside in the homes of relatives. Currently in Cook County, 70 percent of relatives providing care are grandparents.

An aging care giving population has implications for children's permanency and safety. Also the state must foster the well-being and sensitive service needs of older caregivers. Because of the problems identified in a series of its investigations the Inspector General and the Department established a workgroup to develop a pilot problem-solving model to assist staff and the Department's contracted service providers to work more effectively with older caregivers. The goal of this model is to establish a stronger support system that will help the caregiver continue to care for the child, and in cases where that is not possible, assist the extended family in making a new and more appropriate arrangement that ensures the safety, well being and permanency of the child.

The workgroup identified the following concerns impacting the safety and permanency of children:

- The omission of full and accurate health information of caregivers in court documents
- Failure to incorporate relevant medical information into permanency planning
- Unsafe and inadequate housing and the waiving of foster home licensing standards affecting children's safety
- Absence of back up care plans involving extended family members
- No evaluation of financial viability
- Exploitation of caregivers by relatives, financial institutions, and occasionally, adolescents in their care
- Inadequate case planning and follow-up
- Ignoring a life span approach as it affects permanency for young children

Following up on the Department's 5+ Special Review of all licensed foster parents and unlicensed relatives caring for five or more children, the workgroup initially targeted a sample of caregivers who were age 65 and older and caring for five or more children. However, the target population was expanded to include a family with fewer children who encountered similar problems. The model has three components:

- Assessment
- Provision of specialized elder support services
- Family mediation

[1] In 1997 the number of children in the State's care peaked at 50,727.

Assessment of the family needs to address the following aspects of family life and caregiver's status in order to determine the long term parenting capability of the caregiver:

- Personal Information
- Support Network
- Parenting History
- Physical and Cognitive Status
- Financial Information/Housing
- Capacity to Complete Everyday Tasks
- Relationship with Foster/Adoptive Children

Specialized elder support services are needed to address health, housing, financial, and legal issues facing the older caregiver, oftentimes using professionals with expertise in the fields of aging and housing.

Family mediation is a confidential forum that provides the opportunity for extended family members to come together to develop solutions. With the assistance of a professional mediator, the family focuses on immediate concerns and/or planning for future contingencies.

These cases posed a particular dilemma. On the one hand, there were DCFS wards in placements that were less than ideal from the perspective of achieving permanency for these children. On the other hand, the vast majority of these children had deeply bonded with the older caregivers who had given them so much love and attention. How can child welfare workers respect the efforts of the older caregivers and their emotional attachments with the children and still not compromise crucial licensing standards and jeopardize child safety? (Three of the four families experienced a fire incident in their homes in 1999 and before intervention was initiated by the workgroup.) Even more importantly, how can the caseworkers ensure emotional stability and minimize trauma for these children in situations where the probability was high that their current primary caretaker will be unable to care for them throughout their childhood and adolescence?

Although permanency for most of the children in these families has not been achieved to date, the children remain within the families and their safety is more secure. One of the more valuable aspects of this model is that it offers a method to engage families as evidenced by the level of participation of extended family members in discussion, decision-making, and in some cases, in the care of the children. However, follow-up is necessary to keep extended family members involved once their participation is initiated.

Finally, in the course of developing this model, a milestone was achieved with the development and use of a comprehensive medical report form to be completed for all foster care license applicants and every four years for license renewal purposes. Pre-adoptive parents will be required to have a medical report completed as part of the adoption process and if the most recent medical report is more than a year old. This report will enable comprehensive and accurate health information on adults to become part of critical thinking and decision-making while the child is in the state's care.

Transfer of Responsibility for the Model's Implementation

The south and west sides of the city of Chicago have the highest concentration of adoptive homes headed by parents who are 60 years of age and older. Subsidized guardians of all ages are concentrated in the same two geographic areas of the city. (See Appendix for Distribution of Families by Zip Code, City of Chicago.)

The Department agreed to support the start-up of at least one team of professionals to work with families on the south side of the city beginning in fiscal year 2001. The private agency's team will initially consist of two social workers having expertise in elder care and child welfare, and a finance/housing expert. This private

agency has a history and track record of services to children and the elderly.

It is recommended that the Model be housed under the purview of the Department's Best Practice Initiative. A reconfigured workgroup would assume responsibility for providing oversight, direction, and consultation to the teams and on each family. Caseworkers already assigned to families will be expected to participate fully in the problem-solving process. Expertise among workgroup members should at least include permanency and adoption, foster home licensing, elder abuse/elder care, and housing. Participation of the Office of the Inspector General - Best Practice will continue. Emphasis is given to collaboration and information sharing across programs, to ensure that everyone benefits from this model.

OLDER CAREGIVER PROBLEM-SOLVING MODEL

Assessment

A crucial issue in the assessment of any prospective foster/adoptive home is the parenting capability of the caregiver. While the age of the prospective caregiver is not in itself an indication of diminished parenting capacity, child welfare workers must be attentive to the fact that older caregivers are at greater risk of serious health conditions and physical impairments that can pose long-term concerns for the safety and stability of the foster care or adoptive placement.

Therefore, assessments of these homes must place significant emphasis on a constellation of issues that could affect the placement of the foster/adoptive child and the well being of the older caregiver over time. It cannot be overstated that a careful initial assessment can establish a guideline or template through which placements in the home are evaluated.

One principle that guided the work of the workgroup was that the placement of children in the homes of older caregivers impacts the lives of the caregivers as well as the lives of the children placed in their care. The issues surrounding the health and welfare of the older caregiver are as vital to the success of the placement as any of the other issues that are considered.

With this in mind, the workgroup developed an assessment protocol that explicitly considers issues associated with older caregivers. This protocol incorporates case management tools developed and used by the Illinois Department on Aging (IDOA) and the Chicago Department on Aging (CDOA). These tools include the Mini Mental State Exam (MMSE), the Benefits Eligibility Checklist (BEC), and the Determination of Need (DON).

The primary objective of any assessment is to gather information from which to form an evaluation. Obviously, knowledge of geriatrics and the inherent characteristics of older adults can be very helpful in assessing the older caregivers of children. However, good common sense is the most helpful element in putting together a comprehensive and useful assessment. The caseworker should ask her/himself at every step of the way, what am I seeing here that elicits my concern? The following is a list of some of the issues that any comprehensive assessment of older caregivers should consider.

Personal Information:
What is the marital or family status of the caregiver?
Will there be two parents or one?
Does the caregiver have other care giving obligations?
What is the education level of the caregiver? Can s/he read and write?

Support Network:
Does the caregiver live alone?
Who does his or her support network consist of?
Who will step in to assist with the children if s/he gets sick or is otherwise incapacitated?
Is there a well-conceived backup plan for the children? Is it in writing?
Are all members of the plan in agreement with the plan?

Parenting History:
Has the caregiver raised other children, whether biological, foster or adoptive?
Were there any indicated reports against the caregiver?
Have their grown children fared well in life?
Have any of these children been convicted of a crime?
What level of education did these children complete?

Financial Information/Housing:
What is the caregiver's economic status?
Does the older caregiver own or rent?
Does the caregiver still carry a mortgage or loan?
What is the caregiver's credit history?
Can the caregiver responsibly handle monies for the child/ren, or is there a history of bad debt, utility shut-off notices and/or foreclosures?
What is the caregiver's source of income- social security, pension, savings, and employment?
How dependent will the caregiver be on the foster care payments to meet basic needs?
Does the caregiver have medical insurance?

Physical and Cognitive Status:
What is the physical and cognitive status of the caregiver(s)?
Does s/he see a physician regularly?
What physical limitations, if any, does the caregiver have?
Does the caregiver move around easily and get up from a chair without assistance?
Can s/he walk up and down stairs; bend over to pick up a child?
Does the caregiver regularly take medications?
Does the caregiver have any chronic or degenerative conditions?

Capacity to Complete Everyday Tasks:
Can the caregiver do the grocery shopping, laundry; get the child/ren to a doctor's appointment?
Can the caregiver give important information (e.g., child's school and health) clearly and accurately?
What does the home environment look like? Is it dirty, cluttered, or in disrepair?
Is there access to public transportation?
Does the caregiver exhibit any bizarre, paranoid, or delusional behavior or ideas?
Does the caregiver show any sign of dementia?

Relationship with Foster/Adoptive Children:
How do the caregiver and the children relate?
Can the caregiver physically handle the children in his or her care? (Pay particular attention to the number of children, their ages, and any special needs.)
Is the caregiver willing to discuss frankly questions about their long-term ability to care for the child/ren?

Each assessment of an older caregiver should cover the questions suggested above. The tools available through CDOA and IDOA can help in answering many of the relevant questions but should not be seen as an alternative to attentive, practical and common-sense interviews with elder caregivers, their families, support

networks and, when appropriate, the foster/adoptive children in their homes.

Housing

Community planners and sociologists increasingly recognize how important it is for older individuals to remain in their own homes and communities. State and municipal administrators throughout Illinois have recognized the contributions of the senior citizen and have responded by investing in housing and initiating programs that allow seniors to avoid institutionalizations.

Furthermore, the State of Illinois - through the implementation of DHS policies - acknowledges the senior citizens' potential for providing strong family units. Under the terms of the 65+ Foster Parent Program, not only do seniors stay in their homes, they also take on the care of and responsibility for minors. Because of the many issues inherent to the aging process, the question arises, what physical environment do older foster caregivers require in order to be productive? How can these older caregivers raise these children in a loving environment while coping with the limitations brought on by aging?

To age in place comfortably, seniors require certain basics in their physical environment. Safety and security are the primary concerns of senior citizens. According to senior housing experts, seniors will sacrifice other values in order to feel safe and secure. Privacy, physical and emotional comfort, and ease of usage are other high priorities. Therefore, it follows that in order to get the best performance from older caregivers the living environment in which they raise foster children should be safe and secure. To foster maximum opportunity for the nurturing and enrichment of young children and teenagers, the caregiver's household should allow for privacy, comfort and ease of usage.

Safe and Secure Senior Housing

As with all housing, senior housing must have structural integrity. The roof must not leak, the furnace, heating and air conditioning systems must be safe and effective and the exterior should not contribute to neighborhood blight. In addition to the basic standards for housing, housing for older caregivers should be adapted to what they value as they age in place. According to the Stein Gerontological Institute, persons 65 and older experience a high rate of in-home accidents because of lessened physical ability that comes with aging combined with the older homes many seniors live in which are more difficult to manage and navigate.

The most common home accidents are falling on stairways, slipping in bathtubs and showers, and tripping. Burns from stoves or scalding water also account for a high percentage of home accidents among elderly residents. In Illinois approximately 73% of persons 65 and older own their own homes. These homes often are most in need of repair. To offset this deficit and make life safer for older caregivers and ultimately for the children in their care minimum standards should be in place:

- Stairs in good repair with non-slip edgings
- Reinforced railings and handrails on every stairway exterior and interior
- Non-slip smooth flooring especially in the bath and kitchen
- Grab bars in bath and shower areas
- Flexible tubing on gas fixtures (stoves and dryers)
- Solid porches with handrails and non-slip edgings
- Unbroken sidewalks

Most important to seniors is the knowledge that their home is crime-proof. A home that minimizes the opportunity for unwanted intrusion is the foundation from which a senior can be secure, mobile and productive. Senior homes must be as crime proof as possible. The following are basic steps that must be taken to ensure the safety of seniors in their homes.

- Solid secure entrances both front and back
- Dead bolt locks (Never double key locks)

- Removal of any improper entrances
- Knob locks for the senior's bedroom area
- Crack free windows
- Locks on windows
- Secure basement windows and doors
- Lighting for gangways, yards and porches
- Garage and other outdoor buildings well secured
- Trimmed back bushes and shrubs

Ease of Usage

Closely related to the need to provide a safe environment for seniors is the need to make the environment user friendly. Older caregivers should have every physical support available to carry out household chores and tasks with a minimum of strain. Shortened reach capacity and lessened muscle strength affect stooping, bending, sitting and standing. Opening high cupboards, manipulating out-dated controls, climbing small ladders, getting up from deep chairs and stepping up and down can be unnecessarily painful and tiring for seniors experiencing the onset of arthritis or other symptoms of aging.

Schools of architecture specializing in gerontology such as the University of Southern California promotes the concept of ergonomic task centers within seniors' homes. Creating efficient and strength saving work areas in seniors' homes should be a long-term goal. Retrofitting kitchen, bath and clothes washing areas should be immediately addressed. The following are steps that can be taken to conserve seniors' energy:

- Remove all surfaces that produce glare
- Change knobs to easily manipulated handles
- Upgrade or adapt small appliances to meet the requirements of the user
- Lower upper level cupboards where needed
- Create open space under counters to accommodate a chair
- Install lever type handles on kitchen sink
- Insulate pipes under sink to prevent burns to seated persons
- Replace bath with roll in shower
- Install seat in bathtub
- Hang bathroom doors to open out not into the bathroom
- Front mounted controls on all appliances
- Create flexible space and storage areas

By creating a living environment that promotes the comfort and safety of older caregivers, we can improve the quality of life for the children in their care.

Family Mediation

One of the challenges in developing both a care and protection plan for the present and a contingency plan for future situations is having the appropriate forum for discussing such plans. In recent years child welfare agencies have had success using family mediation as the forum for having discussions of this kind.

Mediation is the preferred forum for developing a care and protection plan for several reasons. First, it provides an opportunity for all of the key members of the family to hear the same information so that they all have an understanding of the relevant requirements and resources. Most mediation sessions begin with an Information Sharing session. This allows the caseworkers to explain the situation from the agency's point of view and to outline the issues that must be addressed.

Second, mediation is a formal process. This can be helpful to the family because they can state their own concerns within the context of an official forum without offending their loved one. Because of the great love and respect that family members have for older caregivers, it is often difficult for them to raise their concerns

about the caregiver's possible limitations. Therefore, it can be harder to develop a successful care and protection plan for the children because the family is uncomfortable stating the full facts of the situation. These caregivers are rightfully proud of their independence and are often very sensitive to suggestions that they are not as physically competent as they used to be. For instance, a nephew can offer to stop by the house several times a week to help out because the caseworker has observed that the caregiver has difficulty with certain tasks like shopping, doing the laundry or cleaning the house. Without an official forum, he may have been reluctant to offer his assistance even though he had also noticed the same difficulties.

A third reason for using mediation is that it is a private discussion. Although it results in a care and protection plan that can be entered into court proceedings, it is done without the presence of any caseworkers or others involved with service provision. The courts recognize the privacy of mediation so that anything that is said in mediation cannot be subpoenaed. It is important to note, however, that if a caseworker attends a mediation session, s/he can be subpoenaed to testify regarding what was said, so that caseworkers and all persons with official obligations - must be very careful not to attend.Mediation is appropriate in all cases where there is a set of adult relatives who are involved in the lives of the child/ren and where there are significant decisions that need to be made about the care of the child/ren. These can involve issues of immediate concern or planning for future contingencies. The caseworker should begin planning for a mediation session as soon as both criteria have been met.

One final note: it is important for all participants in mediations to be mentally competent and fully alert. Because of the stakes involved in these discussions, the participants need to be able to think clearly in order to develop a plan that ensures the best outcomes for the child/ren. If there are concerns about the mental health of a possible participant, these need to be resolved before the mediation, preferably by having the person evaluated by the appropriate professional. Furthermore, no one at the mediation should be intoxicated.

Stages of the Mediation Process

Pre-Mediation

The first step in guiding a family through the mediation process is to gather information about the family. Much of the information should already be available to the caseworker. This includes CANTS/LEADS information (including the underlying documentation of any arrests and convictions), a social history form, a child data sheet, and any relevant
documents about the medical condition of the child/ren or their caregivers.

New data will also need to be collected. This includes a genogram, a family tree, the names, addresses, and phone numbers of pertinent relatives and family friends, and the child's statement to her or his family. (See "My Statement to My Family" form in the Appendix.)

The second step is for the caseworker to contact each of the people listed by the caregiver. The caseworker needs to understand the family dynamics, particularly who gets along with whom and who can be counted on to complete central tasks.

The third step is actually organizing the mediation. One of the most time-consuming tasks for the caseworker is actually scheduling the mediation itself. Caseworkers have reported that it can take up to fifteen hours to schedule the mediation. There are numerous schedules to contend with and it often takes multiple conversations with each person to find a time that is satisfactory for all parties. The schedule of the mediator also needs to be taken into consideration. Past experience with mediation indicates that the early evening is often the best time to hold a mediation session.

One of the central functions of the pre-mediation stage is to educate the various family members about the case and about how they can help their loved ones. It is only by educating them that they can fully participate

in creating a successful care and protection plan. With this in mind, it is very important to have input from experts about key aspects of the case, and in most instances they should attend the session to outline options and resources. In working with this model, experts have included a geriatric social worker, housing specialist, elder law attorney, and medical personnel. Their schedules need to be accommodated as well.

Mediation

The mediation session has several distinct components. First, the mediator introduces him/herself and reads a statement and provides a written copy of the statement to family members. The statement is designed to notify the parties of their rights concerning legal counsel, confidentiality, and limits on involving the mediator or the mediator's records in litigation or other proceedings.

Then the mediator has each person involved with the mediation identify him/herself. This sets the stage for the Information Sharing part of the mediation. First, the caseworker or supervisor provides the agency's perspective on what the issues of the case are and how they might be handled. Next, people with expertise about particular facets of the case are given the opportunity to share what they know. For example, a housing specialist was brought in to discuss the family's mortgage and very high interest rate. She then presented several resources that could help the family re-negotiate their mortgage, thus shoring up their financial situation. In another instance, a caregiver and her extended family members were shown how to understand an Asthma Action Plan to help monitor a child's asthma. A final example is the family that was introduced to the latest information on substance abuse treatment programs to help them understand which ones work better than others and also how to manage the mother's substance abuse recovery while her body adjusts to the medication for her bipolar disorder.

The family members are encouraged to ask any questions they have throughout any part of the Information Sharing session. In addition, this is often the part of mediation where they vent their own frustrations with the process. It is very important to listen attentively to their complaints because it is usually the first time that the family members have brought up their concerns and they need to know that they will be listened to and respected. Hopefully this will allow for misunderstandings to be corrected and ensure that the caseworker and the family are working with a similar set of assumptions.

Once everyone has had a chance to share, it is time for the actual mediation to begin. As mentioned earlier, this means that everyone other than family members and the mediator must leave. Although each mediator has his or her own style, the basic stages of the mediation process are usually the same for every mediation session.

First, the mediator will help identify any issues that the family has over and above the issues highlighted by the caseworker. On some occasions, these issues will stem from personal conflicts within the family. The mediator is trained to frame the issues in a neutral manner and to avoid any issues that are not clearly related to the future goal.

The service model proposed here draws from the task-centered treatment model pioneered by Laura Epstein and William Reid. In many situations there are a large number of issues to be addressed. This can make the problems seem so large as to discourage the family. Therefore, it is pivotal to break large issues down into several smaller ones so that the family feels that the situation is manageable. Furthermore, it is important to prioritize issues so that the family has a clear sense of what needs to be done in the immediate future and what may be put on the back burner for the time being.

Once the full set of mandatory and family issues are clearly articulated, the mediator then has the family discuss alternative plans for resolving these issues. The possible outcomes and consequences for each alternative are considered. The next stage involves the negotiation between family members as they debate the alternatives. The mediator's tasks are to help the family know how their stated positions are related to their needs and interests and to help the family accentuate areas of agreement.

The last stage is finalizing agreement. This involves writing up a Care and Protection Plan for the children in which the goals and the tasks necessary to achieve them are clearly stated. It is imperative that the mediator ensures that all tasks are clearly defined and attainable within a reasonable time frame. Vaguely written tasks can lead to confusion and make it difficult to determine if progress is being made. This agreement is what is presented, if necessary, to the courts, so it is crucial that it is written so that all parties understand their obligations.

Post-mediation
The period after the first mediation is a critical time in a case. If progress is not made at this juncture, dissention may flare up within the family or dissatisfaction with the caseworker may emerge. Family members need to know that they can make a difference if they come together as a unit. The caseworker should be very active in assisting the family to complete the tasks listed in the Care and Protection Plan.

It is often necessary to have more than one mediation session. Any significant change in the family's circumstance can trigger the need for a mediation session. Family members are empowered to call for another mediation themselves if they feel it is necessary, this is called a recall mediation. Often more relatives will become involved in the family's efforts to resolve their difficulties and a follow-up mediation can help include them in case planning.

It is critical that throughout the mediation process, instructions are always presented clearly to family members, especially the older caregiver.

Time Frame
There is no hard and fast time line for satisfactory completion of services to these families. Time flexibility is an important ingredient -- some families will require more time than others dependent on the number and complexity of issues. Unanticipated events or delays should be expected. Following the guideline of service providers who address the needs of elder persons, three to sixteen months is a suggested time line for involvement with the family:

Months 1 – 3	Initial assessment. Determine the caregiver's eligibility for services to aging persons, and child welfare service needs. This is a period of upfront, intensive delivery of services.
Months 4 – 16	Continued problem-solving activities, follow-up, ongoing assessment and monitoring

Training
Training will be developed and coordinated with Best Practice. Training curriculum will emphasize a life span approach to making permanency decisions; working with older caregivers with respect, sensitivity, and recognition of the challenges of caring for a second family; specialty service needs and resources; and collaboration.

Case Studies
In order to help front-line professionals translate the previous discussion into concrete case management activity, the following are actual families involved in this model. Names have been changed to protect their privacy.

As of the date of this report, the following four families have been involved in this model from four to eleven months.

Appendix C

A. The Lee Family

Personal Information:

Mary Lee is a 71-year old retired widow. She and her husband had a joint foster care license until his death in 1995. Mrs. Lee continued to foster parent. Between June 1997 and January 1999, Mrs. Lee adopted seven of the eight foster children in her care. Six of the eight children were seven years old and younger. Mrs. Lee was about to adopt the eighth child when she came to the attention of the workgroup. Clearly, a life span approach was not considered in the adoption decision-making process involving these young children and Mrs. Lee.

Two home visits were made in March 1999 for observation and assessment purposes. It was learned that in addition to the children, Mrs. Lee was caring for her 89 year old aunt, who had been living with the family for nearly three months. Mrs. Lee was also providing after school care for her two great grandchildren until her granddaughter picked them up after work.

Parenting History:

When Mary Lee and her husband were first licensed to foster parent, Mr. Lee was 61 years old and retired; Mrs. Lee was 58 years of age and employed as a nurse's aide. All of their own children were grown and living outside the home. (Mr. Lee had three children from a previous marriage and Mrs. Lee had one son from a previous marriage.) The Lees encountered problems foster parenting teenagers. In 1994 Mr. Lee was indicated for substantial risk of sexual harm was he was reported to have inappropriately touched two different girls. During this time, the Lees admitted to using corporal punishment with one of the foster children. Mr. Lee passed away several months later in 1995 and Mrs. Lee accepted only young children to foster parent.

Mr. Lee's children are reported to have fared well in life. Mrs. Lee's 52-year old son, Alfred Hampton, was recently unemployed and moved in with Mrs. Lee and the children. He has a grown daughter and two grandchildren.

Physical and Cognitive Status:

Initially, Mrs. Lee claimed to be in good health outside of having arthritis. The social worker observed her swollen feet and ankles. Mrs. Lee is a heavy-set woman who has difficulty with walking and climbing stairs. The geriatric consultant met with Mrs. Lee who admitted that she is on medication for hypertension, but discounted any real or potential impairment that her weight and hypertension present to her ability to care for eight active boys. Mrs. Lee showed the consultant a recent physician's assessment. The consultant was concerned with the overall quality and accuracy of the assessment of Mrs. Lee, which stated that she could actually stoop, bend, kneel and reach when it was obvious that this was not the case. With Mrs. Lee's permission, the consultant contacted her physician who reported that Mrs. Lee suffers from a progressive respiratory disease. He admitted to giving Mrs. Lee a limited assessment of her mobility. He also opined that the children give her the will to live.

Support Network:

Mrs. Lee's son, Alfred Hampton, often stays at the Lee home. He helps his mother with laundry and grocery shopping. Mr. Hampton has one adult daughter and two grandchildren. Mrs. Lee's stepson and his wife live nearby. They adopted three children, two of which are siblings of two of the children adopted by Mrs. Lee. She has a 50-year old brother who visits and occasionally helps with the children.

Relationship with Foster/Adoptive Children:

There is a real sense of belonging in this home. All of the children appear well cared for and are caring towards each other and Mrs. Lee. Mrs. Lee is strongly attached to all eight children. She is a very caring, kind woman who loves her sons. She appears to maintain an organized household. The children were playful without being out of control.

Two of the eight children are in special education. One four-year old child was non-verbal at the time of

placement. One child, who was born substance exposed, is developmentally delayed and receives physical and speech therapy. Two biological brothers were sexually abused prior to placement. Case records sh ow that all eight boys have made significant developmental and academic gains since their placement with Mrs. Lee. In spite of the positive report, Mrs. Lee is clearly an overburdened caregiver.

Financial Information/Housing:
Mrs. Lee owns a single-family home in a Chicago suburb. The home is on a quiet street of modest single-family homes. The Lee home is in violation of significant foster home licensing standards. The three-bedroom home was found to be overcrowded and could not comfortably accommodate eight children and three adults. Five boys share a bedroom, three boys share a room, and Mrs. Lee and her aunt share the third bedroom. (Alfred sleeps in the basement.) The children's bedrooms were cluttered with clothing and toys. The living arrangement is not because of poverty and five children in one bedroom is beyond a reasonable expectation of children to adjust.

Mrs. Lee's ability to handle safety and emergency situations was of concern because of the combined factors of (1) the number and ages of the children, (2) the age and frailty of a family member, and (3) Mrs. Lee's health and age.

On April 14, 1999, at approximately 5:00 p.m., there was a fire in the Lee home. Fortunately no one was hurt. The fire incident report and a telephone contact with the municipal's Deputy Fire Chief revealed the following:

- No smoke detectors in the home
- The Lee home was in violation of the municipal fire code. The violation was reported to DCFS. The DCP investigation was unfounded.
- The fire originated in the bedroom of the five children, which was cluttered with clothing and toys. Severe damage to a section of the house required temporary housing and clothing assistance for the family, which was arranged by the Red Cross and a local human service agency.
- When the firemen arrived, ten children and two adults (Mrs. Lee's son Alfred and her aunt) were accounted for. Mrs. Lee was not home at the time.

Mrs. Lee owns the home and sizable property with room to expand the house. Prior to the fire, she acknowledged the need for more space but said she was not financially able to expand. Mrs. Lee has a mortgage. She receives a widow's pension of $549 per month. She also receives her own monthly social security of $512 and $600 a month from her aunt. The children's subsidies bring an additional $3,200. Her estimated total monthly income is $4,300 to $4,800.

Interventions/Services:

- Because Mary Lee was still foster parenting one of the eight children, DCFS could apply foster home licensing standards and require that she comply. The first concern was Mrs. Lee's health and its implications for parenting capability. Mrs. Lee was recommended to undergo a thorough medical examination with specific issues to be addressed by the physician, including her ability to lift, walk/maneuver, bend/stoop; her level of alertness and ability to focus; and her ability to care for eight children and a frail, elderly person. However, because of the family's plan developed in family mediation, the requirement was dropped.
- The workgroup found that there were no formal arrangements in place for the care of Mrs. Lee's

seven young children and foster child should Mrs. Lee become incapacitated or die. There was no will to allow for the distribution of her assets, including her house. In the Lee case as with the other three families, the workers accepted informal arrangements or self-reporting by the caregiver that lacked reliability. When the workgroup first became involved with the Lees, the caseworker said Mrs. Lee reported that the children would go to live with her brother. However, there was no formal plan. As the workgroup moved to formalize arrangements, it became apparent that personal circumstances prevented a commitment from the brother. Formal back up planning efforts need to become commonplace.

- The workgroup brought the family together in a mediation session that was attended by Mrs. Lee, her son Alfred, and his adult daughter. The family identified Mrs. Lee's son, Alfred Hampton, as the back up caregiver. Mr. Hampton committed to being licensed for the purpose of adopting the foster child. Mr. Hampton also agreed to adopt the rest of the children in case Mrs. Lee died before they reached the age of majority. Furthermore, Mrs. Lee was referred to an attorney to finalize a will that would guarantee that her son would have legal possession of the home in the event of her death.

- The municipal fire department met with local school personnel. There is now a formal arrangement in which the schools will notify the fire department of families with five or more children. The fire department will follow-up with an inspection of the home.

- Explore other options for the adoption of the foster child.

B. The Finley Family

Personal Information:

Yvonne Finley is a 69-year old homemaker. Her husband, Everett Finley, is a 70-year old retiree. They live in a three-flat building that they own on the West side of Chicago. In 1992, they became relative foster parents to two of their grandchildren. These grandchildren had half-siblings who were also placed with the Finleys in order to keep the sibling group together. By 1994, the sibling group consisted of one sister and five brothers and all of them have been living with the Finleys.

By 1996, all relative foster homes had to meet regular foster home standards. At this time, the Finleys were denied a license because they failed to meet several key standards. There were particular concerns about the mental health and cognitive abilities of Mrs. Finley and the cleanliness of the home. However, the Kinship Care Unit of the agency servicing this case overruled the Licensing Unit's decision to deny the license and the Finleys began to receive foster care payments once again.

Parenting History:

There are no indicated reports against the Finleys. Mr. and Mrs. Finley have raised at least six children. The caseworker working with the family has been unable to contact three of the six children in order to involve them in case planning. The three most involved children seem to have become functioning and productive adults. Marianne is a long time employee of the government. Paula is raising a family of her own. Although Leroy has a long history of criminal activity, he has been gainfully employed since his release from a federal prison more than a year ago.

Support Network:

The Finley's children are their main support system. Their daughters, Paula and Marianne, have been the most consistent sources of support for Mr. and Mrs. Finley. Paula lives a few blocks away and stops in almost every day to help her parents in caring for the children. She also assists with the children's school needs such parent teacher conferences. Marianne lives in a neighboring state but she visits often and she is a strong presence within the family, especially when it comes to negotiating difficult situations. Leroy lived for a time in the basement of the Finley's building and he does help his parents out in various ways. Even though

he is the father of the two oldest children, he has not taken an active role in their care. He is a part of his children's lives but he has resisted being directly involved with any services for the family. Leroy is not expected to assume full responsibility for his children.

Physical and Cognitive Status:
The foster home licensing file contains a 1995 evaluation of Mrs. Finley that gave her a diagnosis of psychosis. She does not demonstrate any significant cognitive impairment. Mrs. Finley is obese with mild diabetes and high blood pressure.

Mr. Finley is extremely hard of hearing with some visual impairment. He has some difficulty in moving about.

Relationship with Foster/Adoptive Children:
The oldest children have been with the Finleys for eight years and the youngest children have lived with them all of their lives. The children are bonded to the Finleys and are close to each other. In addition, they respect both Paula and Marianne as legitimate authority figures in the family.

All of the children have difficulty in school. All but one of the children receives special education. When school personnel were interviewed, they described Mrs. Finley as very active in the education of the children. She made many of the appointments to meet with teachers and regularly attended school events. If she could not make an appointment, Paula went in her place. Interestingly, some teachers were unaware that Mr. Finley was still alive. He does not seem to be active in this part of the children's lives.

Financial Information/Housing:
In 1996, the Finleys obtained a three-flat on the West side after the death of Mrs. Finley's brother, who owned the building previously. They lived in the first floor and they rented out the top two floors. It is unclear how consistently these rental units produced an income for the Finleys. Because of the dangerous and dilapidated condition of the garage, the Finley's were cited for a building code violation and summoned to Housing Court. The garage was torn down and the Finley's paid the required court costs. However, because they failed to register the payment with the County Clerk's Office the City of Chicago placed a lien against the home because of safety concerns about the garage. The lien prevented the renting of the apartments for an extended period of time.

The Finleys' two-bedroom unit is severely overcrowded with eight people living there. There have been persistent problems with cleanliness. In the mid-1990s, there was a recurring problem of ringworm in the children. Very recently, a social worker observed cockroaches in the kitchen of the home.

There was a water leak somewhere in the building that resulted in exorbitant water bills for the Finleys. There have been several shut-off notices from the city regarding this outstanding debt, which currently stands at more than $3,000. The most recent record of the Department of Water billing reflects a significant decrease in monthly water usage and cost. This indicates that the water leak has been successfully addressed. However, the large amount in arrearage persists.

A final cause of great concern is the Finleys' mortgage. The loan comes from a financial company that targets older homeowners with a bad credit history for high-interest mortgages (in this case, the interest rate will increase over time to almost twenty percent). These mortgages have a very high default rate and the Finleys have fallen behind in their payments.

These issues have raised questions about the family's financial stability. Both grandparents receive Social Security payments that amount to approximately $1,000 per month. They receive foster care board payments totaling about $2,000 per month. There has been sporadic rental income that could potentially amount to $1,200 to $1,300 per month, although it is unclear how much they currently receive.

Interventions/Services:

- The first concern was the mental health and cognitive capacity of Mrs. Finley. Because of the diagnosis of "psychosis," all future case planning efforts required resolving this issue. A social worker specializing in geriatric concerns made a home visit and spoke with Mrs. Finley. She outlined the workgroup's concerns and their importance. The social worker referred Mrs. Finley to a hospital affiliated geriatric clinic and physician. An examination of Mrs. Finley ruled out psychosis and clarified the actual state of her cognitive and physical capacities. The evaluation allowed the workgroup to proceed with family mediation with the participation of Mrs. Finley, and more clearly define other crucial elements of the case that needed to be addressed.

- As in the other cases reviewed by the workgroup, there were no formal backup plans for the care of the children in the event that Mr. and Mrs. Finley were incapacitated. The caseworker sought to identify extended family members who might be available to assist in the care of the children. A mediation session was held to develop backup care plans. This resulted in a care and protection plan that would place the children with Paula and Marianne in case of death or incapacitation.

- The mediation session also provided the ideal forum for addressing some of the concerns about the home including what needed to be addressed in order for the children to remain with Mr. and Mrs. Finley. A housing consultant spoke to the family about the lien against the house and what needed to be done to resolve it, the lack of space for the children, and the mortgage. The mediation produced a plan of action for dealing with these complex problems. The family decided to go to the Recorder of Deeds Office to finalize the paperwork that would remove the lien. They also resolved to establish a payment plan that would settle their outstanding water bill. They developed a plan to convert their basement into two bedrooms for the two oldest children, which would provide adequate sleeping space for all six children.
  Arrangements were made for the Finley's to obtain legal counsel regarding their mortgage problems. A lawyer for the Legal Assistance Foundation (LAF) was contacted and agreed to respond to a request for services from the Finley's.

In the aftermath of the mediation, the Finley's began to consider selling their home. At the request of one of the daughters, realtors serving the community where the Finley home is located were researched. The names of three reputable realtors were given to the daughter.

Mrs. Finley went to meet with the attorney from the Legal Assistance Foundation, who determined that the situation was serious and that LAF could possibly help. However, when Mrs. Finley met with another LAF attorney to begin working on the situation, Mrs. Finley failed to mention the mortgage and instead indicated that the water bill was her only problem. Further follow-up with LAF will be attempted.

In spite of all of these efforts, it is proving to be nearly impossible to keep all of the children with the Finleys. The family did not resolve the issues they agreed to at the mediation (except for the removal of the lien). After three months, they had not added the bedrooms in the basement and the mortgage and water bill fell further in arrears. The agency servicing the case did a final licensing report that noted there were no smoke detectors in the house nor was there a fire evacuation plan.

The current plan is to allow the Finleys to keep the two oldest children, ages 16 and 15 (who are their actual grandchildren), in the home. As of this report, the caseworker is following up on the backup plans established at the mediation to see if it is possible to keep the remaining children with family members.

C. *The Reed Family*

Personal Information:

June and Paul Reed are the maternal grandparents and unlicensed caregivers of their six granddaughters. Mrs. Reed is 77 and Mr. Reed is 71 years old. The ages of the grandchildren range from 11 months to 15 years old. Four of the six children were born substance exposed. The grandparents reportedly do not get along with each other; they sleep in separate rooms.

The Reeds have a five-year history of involvement with the Department which attempted to service the mother and her children as an intact family while living with the grandparents. Subsequent to the fourth substance exposed child and an indicated report on the mother for risk of physical injury, the Department was granted custody of the five youngest children and transferred the children and their grandparents to a private agency as a home of relative for services in September 1998. The children's mother, Darlene, is reported to be frequently in the home. Mr. and Mrs. Reed seem to have a different understanding from each other about the length of time the children could be expected to be in their care.

Parenting History:

The Reeds together raised three children. Mr. Reed had four children from another relationship. There were no indicated reports against either caregiver. In addition to the children's mother, Darlene, Mr. and Mrs. Reed have two adult sons. One son lives out of state and is reported to be doing well. The other son, Gary, is married with children. Gary is a college graduate and has fared well in life. Darlene is also an educated woman having completed nearly three years of college. Darlene was traumatized at a young age when she was raped. She is a cocaine user. A background check of Darlene revealed she uses five aliases and was arrested seven times between 1986 and 1996 for prostitution, battery, theft, and assault.

Support Network:

Gary regularly visits his parents and provides them with respite on the weekends by taking the children overnight. Gary told the caseworker that he would adopt the children rather than have them adopted by strangers. Mr. Reed has four children from a previous marriage.

When the family came to the workgroup's attention, DCFS had custody of the five youngest children for less than a year. The family had been with the assigned private agency for about nine months. Fathers of two of the children had maintained involvement and were now working to gain custody of their daughters. Gary Reed was in favor of the fathers taking responsibility for their children.

Financial Information/Housing:

Mr. Reed reported he receives a monthly pension of $200 and $1,250 from Social Security. Mrs. Reed receives monthly Social Security of $418.00.

The Reeds own a single-family home on a quiet street of single-family dwellings on the south side of Chicago. When the family was transferred from DCFS to the private agency in 1998, the agency identified fire, health and safety hazards in the home that prohibited licensure. "Hazardous items throughout the home and on back porch; no smoke alarms or carbon monoxide detectors; not enough beds to accommodate the children, the infant did not have a crib or adequate clothing; broken and/or boarded up windows, no window screens,[2] and dead and live cockroaches everywhere. One bedroom was cluttered and uninhabitable." The two youngest children were sleeping with their grandmother. Mr. Reed reported the house needs a new roof, water heater, and plumbing from the kitchen to the basement.

[2]In 1994, four-year old Sally set a fire in the home. The Reeds did not have fire insurance. The agency found that considerable fire damage still needed to be repaired.

Physical and Cognitive Status:
Mr. Reed is somewhat frail. He suffers from severe asthma, a serious chronic ailment, which requires significant regular medical attention. He sees his physician sometimes as often as every two weeks. Mrs. Reed refused to talk about her health or back up care plan for the children. She did report, however, that she does not regularly see a doctor. Although Mrs. Reed appeared physically fit during a home visit, she was distracted and highly disinclined to discuss the overall plans for the children or to look at possible future problems or concerns. The case record contained a homemaker's report that Mrs. Reed is forgetful.

Capacity to Complete Everyday Tasks:
The private agency arranged for a homemaker for the family. The homemaker provides childcare and housework, three days a week, four hours a day. It had been reported that the grandparents were overwhelmed; that they relied on their oldest granddaughter to care for the infant; and that the granddaughter handled the infant's overnight feedings.
Adequate supervision of the children was questioned when on two occasions two of the children were playing with matches. They burned the bedspread and one child was injured. Regular medical appointments for the children were not being kept. The grandparents failed to obtain medical treatment for their grandchildren at the time of two separate emergencies. A neighbor took one child to the hospital and the other child's father sought medical treatment.

The family's initial caseworker had recommended that the children be removed from the home, but she claimed her superiors denied the request in fear of getting into trouble on age discrimination.

Relationship with Children:
A loving relationship exists between the grandparents and children. Mrs. Reed is reported to be very protective of the children. The homemaker reported a need to keep the children busy during the summer months. However, Mrs. Reed would not allow summer camp for the children.

Intervention/Services:
During the workgroup's involvement with the Reeds, Mr. Reed passed away and Mrs. Reed was hospitalized for pneumonia. Two of the children were returned to their fathers. The children's mother gave birth to her seventh child who is her fifth substance exposed infant.

- The children's mother, Darlene, her brother and two cousins, attended a family mediation session. It was understood that two of the children would be returned to their respective fathers. A care plan for the remaining five children was developed and agreed upon by family members. At the time of mediation, the family reported that an adult family member moved in with Mrs. Reed to assist her and help care for the two oldest children. Four of the children were living with family members, and the newborn was in a foster home. The goal was to create more permanent living arrangements while keeping the children in the family.

- The Reeds had some home repairs made to address safety and energy issues, i.e., new windows, furnace, and exterior siding. The workgroup's housing consultant conducted a housing inspection. She was accompanied by a Neighborhood Housing Services (NHS) representative and a general contractor. The purpose of the inspection was to (1) identify any conditions that would jeopardize the safe and sanitary condition of the home and (2) identify ways in which the home could be more adaptable to the needs of an elderly person. The most pressing needs were (1) to successfully exterminate the infestation of cockroaches and (2) correctly repair a malfunctioning *newly installed* toilet and a *recently repaired* leaking sink. Other recommended improvements included: a new wall around the bath tub with grab bars, new handrail with support brackets along the stairs leading to the basement, a deadbolt lock on the kitchen door that leads to the basement and to the outside, and storm windows on the first floor.

The Reeds met the eligibility requirements for participation in the city's H-Rail program but the waiting list for service by the local provider exceeded 400 candidates. The Reed's community has a high percentage of seniors living in housing characterized by years of deferred maintenance. (A description of housing programs is in the Appendix of this report.)

D. The Starr Family

Personal Information:

In October 1998, 72-year old Sarah Starr adopted six-year old Keenan through a private agency. Six months post-adoption, Ms. Starr was given a confirmed diagnosis of Alzheimer's disease in April 1999. Between September and November 1999, the hotline was called on three different occasions to report that Ms. Starr was unable to care for Keenan and that she and her child were wandering the streets in the middle of the night. Of the two DCP investigations conducted (one report was taken as related information), the first one was indicated for inadequate supervision and substantial risk of harm, the second investigation was unfounded. At the closing of both investigations, the case was not opened for services, the child was not removed, and referrals for services were not provided to the mother and child. One investigator prepared a care plan requiring that one of Ms. Starr's adult children "will move in with Ms. Starr and her son or Ms. Starr will move in with her daughter."

Ms. Starr, who is divorced, has two adult daughters, Josephine Nelson and Theresa Farley, who assist their mother. Josephine visits daily and often takes Keenan to school or returns him home from school. Theresa would check in on her mother on the weekends.

Theresa reported that she and her sister became aware that their mother adopted Keenan after the adoption took place and that they learned about the adoption from their mother. Theresa and her husband were in the process of purchasing a new home and they planned to move Ms. Starr and Keenan with them. (Josephine was unable to take care of both parent and child.)

Parenting History:

Mrs. Starr raised two daughters. Both women are professionals and have families of their own. Neither daughter has ever been convicted of a crime. Mrs. Starr was never indicated for child abuse or neglect until she developed Alzheimer's disease.

Physical and Cognitive Status:

One of the hotline calls had been made by an Alzheimer's Disease clinic that reported that Ms. Starr's disease had reached an advanced stage so that she was no longer capable of caring for her child.

In September 1999, Ms. Starr's physician reported to the child protective investigator that Ms. Starr needs supervision and supportive services. He said her memory loss would become progressively worse and that she cannot be responsible to care for herself or her six-year old child. A neuropsychological test of Ms. Starr in November 1999 indicated her disease to be in the moderate to severe stage.

Capacity to Complete Everyday Tasks:

By September 1999, Ms. Starr required and was receiving homemaker services from the Department of Aging to assist with her care (childcare was not part of the services.) Ms. Starr could no longer drive her car, take Keenan to school, or perform other day-to-day chores and tasks without problems, such as forgetting to turn off the stove.

Financial Information/Housing:

The elder abuse hotline was called in September 1999 to report that Ms. Starr had been swindled out of $30,000. The workgroup later learned that a total of $98,000 had been withdrawn from Ms. Starr's bank accounts. Ms. Starr could not account for the funds.

Ms. Starr lives alone with Keenan on the first floor of a two unit building owned by the family. Three days after the second DCP investigation, there was a fire in Ms. Starr's home. Both she and Keenan were alone at the time and were unharmed. However, the fire damage required that they immediately move in with Theresa and her family.

Relationship with Foster/Adoptive Child:
From all accounts, Ms. Starr and Keenan are very attached and each is protective of the other. Keenan addresses Ms. Starr as grandma. He is loving and respectful toward her.

Interventions/Services:

- The workgroup arranged for the private agency that completed the adoption to service the family.

- A meeting was convened with Ms. Starr's daughter, Theresa, and her husband Bob Farley, to provide them with an opportunity to express their needs and concerns, and to advise them of the workgroup's recommendations. The private agency worker and an assistant state's attorney were also present. The Farleys were clearly overwhelmed with the responsibility for the care of both Mrs. Starr and Keenan. The Farleys work full time and have two children of their own. They were still in the process of purchasing a home. The Farleys arranged adult day care five days a week for Mrs. Starr. The Farleys were experiencing interference from Mrs. Starr in their efforts to care for Keenan, i.e., homework, bedtime, etc. Keenan was experiencing significant stress manifested by soiling his pants.

- The OIG screened in the case at Juvenile Court and temporary custody of Keenan was taken. The case was continued for adjudicatory hearing on an allegation of dependency because of Mrs. Starr's mental status. The judge appointed an attorney to serve as attorney for Mrs. Starr and referred her for the appointment of a private attorney to serve as her guardian ad litem.

The Farleys could no longer care for both mother and child and requested that Keenan be removed from their home. Keenan was placed with a close family friend who is a licensed foster parent and is also caring for Keenan's sibling. Because the foster parent had maintained regular contact with the family, it was anticipated that Keenan would have frequent contact with his mother.

GERIATRIC PHYSICIANS

Rush-Presbyterian-St. Luke's Medical Center
Johnston R. Bowman Center

Geriatric Care Partners:
Dr. Martin Gorbien
Dr. Anthony Perry
Dr. John Wiley
Dr. Jack Olson

Rush Alzheimer's Disease Center:

(Neurologists)
Dr. Jacob Fox
Dr. Julie A. Schneider
Dr. Neelum Aggarwal

Northwestern Hospital

Dr. John Clark
Dr. Beatrice Edwards
Dr. Jeremiah Kelly
Dr. Miriam Rodin
Dr. Janice Schwartz
Dr. Adna Arseven

University of Chicago Hospital

Windermere Center:

Dr. David Rudberg
Dr. Greg Sachs
Dr. Shelley Sternberg
Dr. Dion Cox-Haley
Dr. Paula Padrazik
Dr. Daniel Brauner

Weiss Center:

Dr. William Barnhart
Dr. Todd Grendon
Dr. Martin Siglin
Dr. Annie John
Dr. Shirley Roy

UIC Hospital

Dr. Donald Jurivich (Chief)
Dr. Felipe Perez
Dr. David Staats

Cook County Hospital

General Medicine Clinic:

Dr. Laura Luke
Dr. Perry

RESOURCES AVAILABLE TO MEET SENIOR HOUSING NEEDS
City of Chicago

Home Repairs for Accessible and Independent Living (H-RAIL)
Sponsor: City of Chicago Department of Housing
Description: Program provides enabling devices and an array of non-emergency home improvements to residences occupied by low-income senior citizens. Work is done at no cost to the homeowner or tenant. Not-for-profit groups under contract with the Department of Housing perform the work. The program focuses on three major areas, (1) accessibility, (2) safety/security and (3) weatherizing. Specific services may include door and window repair, installation of grab bars, installation of doors and locks and in some instances installation of new porches and/or ramps. Selected not-for-profit agencies make on-site inspections to determine services needed. Work is completed by the not-for-profit and inspected by the Department of Housing staff. Up to $5,000 for materials may be expended per household; the maximum cost allowed for an individual job depends on the type of service provided.

Homeowners or renters must be 62 years of age or have a permanent disability. Qualified recipients can be the head of household or the spouse. When a renter is approved for assistance, the landlord shall certify that he or she will not increase the rent as a direct result of H-RAIL improvements. Applicants may call the Department of Housing at (312)747-8677 for the name of the not-for-profit Delegate Agency in their community.

Emergency Housing Assistance Program (EHAP)
Sponsor: City of Chicago Department of Housing
Description: A deferred loan to owner-occupants of one-to-four unit residential buildings to repair dangerous, hazardous and life threatening conditions. Applicants shall live in the property and have no other means to pay for repairs. If the property is sold within one year of receipt of the assistance, the entire loan shall be repaid. Otherwise, after one year, the loan is fully forgiven. City assistance ranges from $8,500 to $10,000. From November 1 to April 1, improvements are limited to the repair or replacement of heating units as well as other heat-related repairs. From April 1 to November 1, improvements are limited to roofing, electrical, plumbing and carpentry repairs. Department of Housing staff inspects the property. Licensed contractors selected by the Department of Housing make the emergency repairs. Eligible applicants earn up to 50% of median income. Contact the Department of Housing at (312) 747-8696 for an appointment.

Single Family Home Loan Program
Sponsor: City of Chicago Department of Housing
Description: A rehabilitation loan program available to owner-occupants of one to four unit residential buildings located in Chicago. Following the rehabilitation, the building shall be in compliance with the City of Chicago Building Code. The City will provide between $5,000 and $50,000 per unit. The City's financing will be used for rehabilitation and soft costs. Eligible applicants for one-unit buildings earn up to 80% of median income. In two to four unit buildings the owner-occupant is under no income restrictions as long as all rental units are leased to households earning no more than 80% of median income. Loans are amortizing and forgivable. For more information call the City of Chicago Department of Housing at (312) 747-8589.

Prompting Questions for Family Mediation
(Family members should complete the questions before the mediation session.)

Daily Tasks and Schedules

Mornings

What time do the children wake up in the morning?

Who takes the responsibility for choosing their clothes and seeing that they are dressed?

What kind of breakfast do the children eat and who is responsible for preparing it?

Who makes the beds?

School

How do the children get to school (walk, bus, driven)?

What time do the children come home from school? If someone needs to pick them up, who does this?

Do any of the children participate in after-school activities such as sports, clubs, or church youth groups?

Who ensures that the children do their homework?

Is there a place in the home for the children to do their homework in a quiet and comfortable environment?

Evenings

What time does the family eat dinner?

How are the responsibilities for cleaning up after dinner divided?

What sort of activities do the family members engage in after dinner?

What time do the children go to bed?

Household Chores

Who is responsible for cleaning the children's rooms?

Who is responsible for the laundry?
Gathering and sorting:
Loading/unloading the washer/dryer:
Folding:
Putting the clothes in the drawer:

Who does the yard work (mowing, raking leaves, etc.)?

Who takes out the garbage?

Who prepares the meals?

Questions about the Children

Which of the children is the most outgoing?

Which of the children is the best student?

Which of the children is the most athletic?

Which of the children is the most introspective and reflective?

Which of the children is the funniest?

Which of the children are the closest to each other?

How much responsibility do the older children take for the younger children?

Do the children know what to do in the event of an emergency (who to call, how to evacuate the house, etc.)?

Revised: August 1, 2000

Intact Family Recovery Project

I. Background

In the past fifteen years, parental abuse of alcohol and other drugs has had an increasing impact on the child welfare system. According to the Child Welfare League of America, substance abuse affects as many as 80% of all cases of substantiated child abuse and neglect nationwide.[1] In Illinois a 1998 General Accounting Office (GAO) reports found that 74% of all foster care cases involve parental substance abuse by one or both parents.[2]

One particularly vulnerable subset of these families is that involving substance exposed infants (SEI's). In addition to the obvious health risks, these infants are at greater risk for physical abuse. In studies of the association between substance abuse and child abuse, researchers have found that children born to substance abusing women have a rate of physical abuse two to five times higher than matched children from similar backgrounds but with no history of prenatal drug exposure.[3]

In fiscal year 1999, the State of Illinois reported 1645 indicated or substantiated SEI cases.[4] Of these, 785 or 48% were subsequent SEI's.[5] Although the state has reported a 52% decrease in total indicated SEI cases since 1996, the number of subsequent SEI's has remained around 50%.[6] Given that nearly one-half of all SEI's reported to the Department have a substance exposed sibling not only indicates a high degree of addiction severity, but also that prior services may have been inadequate in addressing the family's substance abuse needs. Delivering a SEI warrants a more aggressive, comprehensive approach to child welfare and substance abuse services than these families have received in the past.

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[1]Child Welfare League of America. (1989). *Highlights of Questions for the Working Paper on Chemical Dependency*. Washington, DC: Child Welfare League of America.

[2]U.S. General Accounting Office (GAO) (1998). *Foster Care: Parental Substance Abuse Presents Obstacles for Securing Safe, Permanent Homes for Children*. Washington, DC: U.S. General Accounting Office. GAO/HEHS-98-182, p. 7.

[3] Chasnoff, I. (1998). Silent Violence: Is Prevention a Moral Obligation? *Pediatrics*. 104, p. 146.

[4] Illinois Department of Children and Family Services Division of Quality Assurance (February 2000). *Executive Statistical Summary*.

[5] Illinois Department of Children and Family Services Division of Quality Assurance (June 2000).

[6] As stated in DCFS Office of the Inspector General, *Recommendations for Improving the State's Child Welfare Response to Families Affected by Parental Substance Abuse* (December 1996), the decrease may have been a result of managed care and Medicaid policies regarding testing or that costs associated with keeping reported infants in the hospital while DCFS makes a determination as to the child's custody has led to hospital staff performing fewer toxicology screens. Since 1996, the improving economy may be a factor in the continued decrease.

This figure contradicts the percentages reported in *Substance Exposed Infants and Their Families* (38% versus this report's 48%): *A Protocol for Clinical Practice and Collaborative Intervention*. Illinois Department of Children and Family Services, March 1996, that was referenced in Office of the Inspector General (December 1996). *Recommendations for Improving the State's Child Welfare Response to Families Affected by Parental Substance Abuse.*

OIG investigations reinforce this need and highlight the tragic consequences of not providing adequate services.[7] Through these investigations, the OI G has determined that traditional intact services through the Department provided little contact for a time period too short to adequately address a family's substance abuse needs. Further, workers and supervisors lacked substance abuse knowledge to link parents to an appropriate treatment and maintained poor communication and follow through with treatment providers. Outcomes of traditional intact services included cases being closed to the Department without a clear understanding of whether or not the parent had completed substance abuse treatment as well as births of subsequent SEI's, many of which eventually resulted in placement into foster care. In 1996 these findings prompted the Department and Inspector General's office to develop, through a Best Practice Project, the Intact Family Recovery (IFR) project.

II. Project Description

The IFR project is a three year field study funded through the Department to provide integrated child welfare and substance abuse services to intact families in an effort to increase child safety and the family's capacity to effectively participate in substance abuse treatment while increasing retention and completion of mothers in treatment. Referrals into the project include families who have delivered a first or second SEI. Because Cook County historically represents approximately 80% of all SEI indicated cases, partnerships, which consist of a private child welfare and substance abuse treatment agency, have been established in the three Cook County Regions. Serving Cook North is Lutheran Social Services of Illinois (LSSI) in partnership with C4/Recovery Point; Cook Central, Lutheran Children and Family Services (LCFS) in partnership with The Women's Treatment Center (TWTC); and Cook South, LSSI in partnership with Gateway Foundation.[8] Although the configuration varies slightly among the regions, each team consists of approximately one child welfare supervisor, seven child welfare workers, one substance abuse supervisor and two substance abuse case managers.

In addition to developing the model, the OIG is responsible for monitoring and supporting the partnerships. Methods for doing so include weekly consultation at case staffings, monthly data collection, monthly supervisor meetings convened to identify and address systemic and practice challenges, and monthly training. Further, OIG staff has created tools intended to assist both disciplines in working with families. These tools include *Indicators for Progress in the Substance Abuse Recovery Process Matrix*, a progress matrix containing both child welfare and substance abuse dimensions and *Substance Abuse Recovery: Guides for Parents and Caretakers*, a hands-on guide for workers and parents to be used in the home to help improve basic parenting skills.[9] Support for project administration and direction comes from DCFS Division of Health Policy.

Service Description

Propelled by insufficient services found in traditional intact contracts, the IFR model calls for greater intensity, duration and high levels of collaboration between child welfare and substance abuse treatment providers throughout the life of the case. The following table highlights these distinctions.

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[7] DCFS Office of the Inspector General (1996). *Recommendations for Improving the State's Child Welfare Response to Families Affected by Parental Substance Abuse.* Chicago, IL: Office of the Inspector General.

[8] Chicago Commons and Gateway Foundation originally served the Cook South region. LSSI assumed child welfare responsibilities in March 1999 and C4/Recovery Point assumed substance abuse services in June 2000. As of July 2000, Haymarket Center will assume substance abuse services for Cook Central.

[9] *Indicators for Progress in the Substance Abuse Recovery Process Matrix* was published accompanied with the article *Parental Substance Abuse and Permanency Decision Making: Measuring Progress in Substance Abuse Recovery.* L. D'Aunno & G. Chisum (1998). *Children's Legal Rights Journa*l. Vol. 18. No. 4. pp 52-69.

Table 1. *Traditional vs. Intact Family Recovery Services*

	Traditional Intact Family Service Model	Intact Family Recovery Service Model
Intensity *of contact*	For life of case 2/ month by child welfare worker =. 5 per week[10]	Until parent is actively engaged in treatment (Phase I) • 1/ week by child welfare • 1/ week by substance abuse • 1/ week joint (child welfare & substance abuse) =3 per week Once actively engaged in treatment (Phase II) • 1/ week by child welfare • 1/ week by substance abuse • joint as necessary =2 per week, minimally ***If parent relapses, visits resume to 3 per week until parent stabilizes*** Once parent has completed formal treatment (Phase III) • 1/ week by child welfare worker for 2 months and then bimonthly for life of case • 1 bimonthly by substance abuse worker for 2 months and then monthly for life of case • joint as necessary =1.5 per week, minimally for 2 months and 1.5 monthly for remainder of case
Duration *of time open to Department*	• 12 months or less	• 18 to 24 months
Collaboration *Cooperation between child welfare & substance abuse treatment providers*	• Guidelines for coordination through faxes, phone calls, monthly progress reports and staffings as needed	• Coordinated assessments and service planning • Weekly joint case staffings • Joint home visits • Joint court appearances (if case is court involved) • Monthly cross training on child welfare and substance abuse topics

With increased intensity, duration and collaboration comes an innovative approach to providing services to substance affected families. Once a parent is referred into the project and has agreed to participate in services, both a child welfare and substance abuse worker are assigned. These workers combine efforts and pool resources to ensure child safety, strengthen family functioning and retain parents in substance abuse treatment. Such an approach is possible in part due to caseload size. In traditional intact services, caseloads over the past several years have declined from 20 to 12 families per worker. For the IFR caseloads have averaged around 8 families per worker.

[10] As of January 2000, the Department's Intact Family Services Program Plan states a general expectation that child welfare workers provide weekly visits until the family is actively engaged in services.

Although working as a team, both the child welfare and substance abuse worker assume primary responsibilities. IFR child welfare workers are responsible for the domains of general health, mental health, education and economics. In addition to the general child welfare duties, a special emphasis has been placed on the following tasks:

- ensuring home safety,
- focusing on entire family as opposed to mother/infant dyad,
- ensuring cribs are in the home,
- engaging fathers,
- addressing family planning,
- ensuring up-to-date immunizations,
- completing assessments for and enrolling in early education programs and
- monitoring progress and ensuring school attendance.

Substance Abuse Services

Phase I

IFR substance abuse workers assess substance abuse treatment needs and are primarily responsible for engaging participants in a DCFS-OASA Initiative funded treatment program and monitoring compliance and progress.[11] The substance abuse worker provides case coordination and continuity for clients as they proceed through various levels of treatment, transfer to a different provider (if necessary) and enter into aftercare and mutual help groups in the community. Therefore, even if the participant cannot receive all services in one location, the substance abuse worker is consistent across all treatment experiences, works to reduce relapse and ensure the participant does not get lost in a transfer.

Although treatment is primarily the substance abuse worker's domain, the child welfare worker continues to provide services to the family while supporting the efforts of the substance abuse worker. During the three weekly visits until the parent is actively engaged in treatment, or pretreatment, the team addresses barriers to treatment entry such as childcare and transportation and works to ensure proper post-partum health care. The goal is to ensure child safety, stabilize the household and prepare for the transition into treatment.

Phase II

Once the parent is actively engaged in treatment, the IFR team continues to assess needs, provide appropriate services to the family and monitor the parent's progress through the use of urine toxicologies and unannounced visits. The team will also help the participant to identify a sponsor and link with traditional support and self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and faith-based groups. This treatment phase typically encompasses the longest period of time and is likely to include multiple treatment attempts and relapse. If a participant disengages in treatment and/or relapses, the team will immediately increase the intensity of visits and again provide intensive outreach to re-engage and stabilize the participant. This stabilization may include reassessing and adjusting the level of care or location. A primary focus during this time is to monitor progress, adjust to individual needs and create a seamless treatment experience.

Phase III

After the participant has completed formal treatment, the following phase is recovery maintenance. During this phase the IFR team will focus on encouraging the participant to continue communication with an identified sponsor, monitor attendance at support groups and continue to conduct urine toxicologies. If a participant has satisfied program requirements, remained abstinent for a substantial period of time, has established appropriate supports, and child safety and well-being is assured, a final staffing is conducted. During this staffing the relapse prevention plan is reviewed and the final phase

[11] Treatment assessment and linkage is typically completed within the first two weeks.

of the *Indicators for Progress in the Substance Abuse Recovery Process Matrix* is completed. Once completed the case is closed with the Department.

Court Involvement

> *Treatment does not need to be voluntary to be effective. Sanctions or enticements in the family, employment setting or criminal justice system can increases significantly both treatment entry and retention.*
> -National Institute on Drug Abuse, Principles of Effective Treatment

Before entering the IFR project, parent(s) and workers participate in an informed consent discussion letting the parent(s) know that any safety risk to their children or critical violation of project requirements could result in a hotline call or court involvement. At this time parents are asked to sign a memorandum of agreement, or written contract, which outlines requirements and consequences of noncompliance. Whether or not to involve the court is a joint decision made by the Cook County Juvenile Court States Attorney's Office, the IFR team and legal department of DCFS. Once the decision to go into court has been made, the parties involved will ask the court to enter an Order of Protection instead of taking temporary custody. If the parent complies with the Order of Protection the court will usually vacate the order within six to twelve months. However, if the parent fails to comply with the order, the court may grant a petition for temporary custody and placement of the children into foster care.[12]

89% of IFR participants enter recommended treatment within 30 days of the Order of Protection

64% complete

III. Project Data and Discussion

The project began accepting referrals in June 1998, marking two years in June 2000. The following section represents data from the project through May 1, 2000.

Referrals and Current Status

Table 2. ***Referrals. N=187***

Total Referrals		**187**
Number not receiving services due to:		
Declined services	9	
Could not locate parent	6	
Inappropriate referral*	3	
Other	2	
Total	20	**(20)**
Total Receiving IFR Services		**167**

*These cases do not meet program criteria and are returned to the Department for reassignment.

[12] Once a decision to go to court has been made, the parent has approximately three weeks before the actual court date to engage in the recommended treatment. IFR data shows that 61% of mothers *who enter the recommended treatment*, enter prior to the court date; 39% enter on or after the scheduled court date.

Intensity and Duration of Services

In an effort to determine actual intensity, the OIG has begun analyzing the number of home visits the child welfare and substance abuse workers document. This documentation comes from client contact summary sheets that both workers complete independently.[13] The following table presents findings from 14 active cases that are in Phase I or II of the program.

Table 3. ***Visits by Worker and Phase. N=14***

	Prior to Treatment Engagement (Phase I) N=9*	**Once Engaged in Treatment (Phase II) N=13**
	Average Visits/Week	***Average Visits/Week***
Child Welfare Worker	.9	1.1
Joint	.8	.4
Substance Abuse Worker	.6	.6
Total	**2.3**	**2.1**
Average Number of weeks	**5.2**	**18.7****

*1 of these is still in Phase I. This case is not included in the average number of weeks figure.
**These cases are still in the treatment phase and therefore are not a true reflection of how long this phase typically lasts.

As seen in Table 3, average visits in Phase I, 2.3, are slightly less than the expected 3.0, whereas visits in Phase II, 2.1 are slightly more than the expected 2.0. These 14 cases do not reveal the level of intensity needed in the recovery maintenance (Phase III) because these clients are still in treatment. However, partnerships report that due to client relapse programs must often increase intensity of contact during the treatment and maintenance phases. These 14 cases suggest that, in dealing with substance abuse, the required intensity of contact should reflect the client's progress in treatment. Furthermore, whether or not the client enters

treatment in a timely fashion, the first six months are likely to require intense contact (2-3 times per week).

As of June 30, 2000, the partnerships expect to successfully close 10 cases. Phase III analysis has been conducted on five of these ten cases showing that once the mother completes formal treatment, she remains in the program for an average of 42 weeks or approximately 11 months. Total average visits per week for Phase III are .7 and breakdown as follows: child welfare worker, .5; joint, .1; and substance abuse worker, .1[14] The average length of time in the program for the ten cases was 22 months. The project is continuing to collect and analyze actual visit data.

Participant Profile

Table 4. ***Participant Age. N=167***

Range	18-47
Mean	32

[13] Contact begins at case transfer from the DCP worker to the IFR team. Any discrepancies between IFR team members (designated child welfare and substance abuse treatment worker) documentation is not considered.

[14] Formal measures were not in place until after some of these cases had begun receiving services; therefore, Phase III figures are likely to be less than actuality.

Table 5. ***Participant Race/Ethnicity. N=167***

African American	78%
Caucasian	17%
Hispanic	8%
Other	1%

As of May 1, 2000, 187 families have been referred into the project. Of these, 167 families accepted services. The mean age of IFR participants is consistent with both the treatment and non-treatment groups in the 1997 DCFS-OASA Initiative Study (32 and 33).[15] The Healthy Fit Project reports a slightly younger mean age of 29 years.[16]

African-American mothers are slightly under-represented in the IFR sample as compared to the DCFS-OASA Initiative treatment and non-treatment groups (78% versus 82%). The percentage of Caucasian mothers in the IFR is slightly larger than the DCFS-OASA Initiative sample (17% versus 12%). The percentage of Hispanic mothers in the IFR is also higher than the OASA sample (8% versus 3%).

Substance Abuse History

Tables 6 and 7 contain information gathered by the substance abuse treatment providers in their assessment of 125 IFR participants receiving services (unless otherwise noted). Those not represented include some of the earliest referrals that were transferred before formal measures were in place and new referrals in which information is still being recorded.[17] This history is self-reported.

Table 6. ***Drug Type and Years of Use. N=125***

	Primary Drug		**Secondary Drug**		**Tertiary Drug**	
Drug	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Cocaine	62	50%	37	35%	14	23%
Heroin	27	22%	7	7%	3	5%
Alcohol	24	19%	39	36%	14	23%
Marijuana	10	8%	24	22%	28	46%
PCP	2	2%	0	0%	1	2%
Other	0	0%	0	0%	1	2%
Total	**125**	**100**	**107**	**100**	**61**	**100**
Years of Use						
Range	1-25		1-27		1-23	
Mean	9		8		5	

[15] DCFS-OASA comparisons come from: D'Aunno, T. & Marsh, J. (1998). Child Welfare and Substance Use: Findings From a Collaborative Services Initiative in Illinois. *The Source.* Spring. 8(2), pp. 5-7.

[16] Healthy Fit Project comparisons come from DCFS Status Reports.

[17] One exception is the heroin population. As discussed further in the report, inaccessibility to methadone maintenance prompted the OIG to collect data early in the project on this population. Therefore, data reflected in Table 6 might slightly over represent the heroin population in terms of overall percentages. A more precise picture of this population is captured in Table 8.

Table 7. ***Treatment and Detoxification (Detox) Episodes Prior to IFR. N=125***

Number Reporting Prior TX Episode(s)	**54 (43%)**	**Number Reporting Prior Detox Episode(s)**	**17 (14%)**
Range of Episodes	1-8	Range of Episodes	1-6
Mean	1.7	Mean	1.7

Table 6 indicates that 107 of the 125 (86%) IFR participants reported histories of using more than one drug, or polydrug use. Cocaine, heroin and alcohol account for 91% of identified primary drugs and 78% of secondary drugs. Nationally, researchers report that success rates in drug treatment for polydrug abuse that included cocaine are lower than for heroin alone.[18]

During the intake assessment, each client is asked to self-report years of prior substance use. Because of the potential for negative consequences for such a disclosure to one's child welfare worker, years of use are likely to be under reported. The project is considering an exit survey of mothers who have successfully completed treatment as a reliability check against early self-reports.

As seen in Table 7, 54 (43%) of IFR participants report experiencing at least one prior treatment episode (other than detox services). Seventeen (14%) had at least one experience with detox. The DCFS-OASA Initiative study reported similar numbers, with 47% of women surveyed having experienced prior treatment, including detox. Since more than one treatment episode is likely before reaching a successful outcome, this previous experience is considered a strength.

Heroin

Table 8. ***Heroin Population. N=144****

Number of Heroin Users**	**37 (26%)**
Age Range	20-40
Mean Age	33
Years of Use	
Range	1-22
Mean	7
Number on Methadone Maintenance	14
Dose Range***	45–100 mg
≤ 60mg 60-79mg 80+mg	2 2 5

*Includes information on the first 144 participants receiving IFR services.
**Includes heroin identified as a primary, secondary or tertiary drug.
***Range and dose information available on 9 of the 14 participants.

Methadone Dose Range	*Relative Risk of Leaving Tx*
< 60 mg	*100% (baseline)*
60-79mg	*47%*
80+mg	*21%*

Source: Ball and Ross 1991. p.248.

Heroin continues to be the second most common primary drug, with nearly 30% of clients identifying heroin as a primary and secondary drug. Methadone maintenance therapy has been provided to 38% of the heroin-addicted clients (see discussion below). Some IFR participants appear to be receiving sub-optimal doses of methadone (below 60-80 mg.). More work is needed to assure provision of the standard of care to heroin addicted clients.

Of the 27 cases where heroin is the primary drug, 44% have resulted in temporary custody

Overall rate for IFR is 29%

[18] Kosten, T., Rounsaville, B. & Kleber, H. (1987). A 2.5 Year Follow-up of Cocaine use Among Treated Opioid Addicts: Have Our Treatments Helped? *Archives of General Psychiatry* 44: 281-284.

IFR Substance Abuse Treatment [19]

In order to be accepted into the IFR, every mother must agree to enter substance abuse treatment as recommended by an assessment and follow all recommendations. A primary goal of the program is to get mothers into the correct level of treatment and to provide support to keep them in treatment for a sufficient period of time in order to achieve long-term abstinence. Research shows that good outcomes are contingent on adequate lengths of treatment. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness.[20]

> ***According to the National Institute of Drug Abuse (NIDA), patients with moderate or severe problems are significantly more likely to achieve long-term abstinence, if they receive at least 90 days of treatment.***

In 1998, the U.S. General Accounting Office (GAO) released findings of a study that looked at the level of progress of Illinois mothers with children in foster care for at least one year.[21] Table 9 compares progress of IFR mothers with this data.

Table 9. ***IFR (N=144) versus GAO (n= 173)***

Levels of Progress	IFR	IFR %	GAO %
Successfully Completed Treatment*	81	56%	11%
Currently in Treatment	11**	8%	8%
Entered but Failed to Complete Tx	28 (combined =33)	19% (combined = 23%)	42%
Entered but Reason for Discharge Unavailable	5	3%	
Never Entered Treatment ***	17	12%	34%
Other			5%
Heroin participants who followed recommendation to enter methadone detox but failed to	2	1%	

[19] The IFR substance abuse treatment data describes the treatment experience of participants who entered the IFR from the beginning of the program on June 1, 1998 to April 10, 2000 (data from North Cook region) or May 1, 2000 (data from Central and South Cook regions). The IFR treatment data set contains 160 records. Three cases are missing (participant name only). Two of the cases were less than two months old at the time of the last update and were listed as "pre-treatment", i.e., preparing for treatment entry. (Cases over two months old listed as "pre-treatment" (n=1) were treated as having received no formal treatment.) Eleven (11) participants in the data set received no services from the IFR because they could not be located or refused to sign the MOA and were transferred back to DCP. Subtracting the missing, new and no services cases, except where otherwise noted, n=144 for the findings below.

[20] National Institute on Drug Abuse (1999). *Principles of Drug Addiction Treatment: A Research-Based Guide*. NIH Publication No. 99-4180.

[21] U.S. General Accounting Office (1998). *Foster Care: Parental Substance Abuse Presents Obstacles for Securing Safe, Permanent Homes for Children*. Washington, DC: U.s. General Accounting Office. GAO/HEHS-98-182, p.19.

enter other treatment[22]			
Totals	**144**	**100%**	**100%**

*For both groups, describe participants who have completed one or more levels of care.
For IFR, only residential, intensive-outpatient and outpatient stays are included (i.e., recovery homes, detox, and pre-treatment are excluded).
**Excludes 10 participants who entered another level of care following successful completion of one level of care and remain in treatment.
*** Includes 8 heroin participants who were not offered methadone maintenance therapy

Overall, IFR appears to be quite effective in recruiting and retaining mothers in treatment, as measured by treatment completions and numbers of days of participation in treatment.[23]
Eighty-one (56%) of mothers in the IFR have completed one or more levels of treatment, with an additional 11 (8%) remaining in treatment. Only 17 (12%) of mothers failed to enter treatment. The remaining 33 (23%) of mothers entered but failed to complete treatment. [24]

Table 10. ***Days of Treatment for IFR Mothers. N=105***[25]

- Less than 30 days of treatment = 14% (n = 15)
  - Mean length of stay = 15.3 days
  - Median = 11 days
  - Range = 0-29 days
- 30 or more but less than 90 days = 21% (n = 22)
  - Mean = 62 days
  - Median = 68 days
  - Range = 30-88 days
- 90 or more but less than 120 days = 16% (n = 17)
  - Mean = 103.5 days
  - Median = 100 days
  - Range = 92-119 days
- 120 or more days = 48% (n= 50)
  - Mean = 231 days
  - Median = 189 days*
  - Range = 120-438 days

Mothers who experienced 90 or more days of treatment = 64%

[22] Best practice does not support methadone detoxification as an initial treatment. The failure of these mothers to follow through with subsequent treatment should be seen as a failure of the treatment system, not of the participant.

[23] For this report, number of days in treatment refers to total days of participation in treatment whether or not continuous. In future reports, the project hopes to report data on continuous days in treatment.

[24] The 23% non-completion rate includes 5 clients (3%) for whom no reason for discharge was reported.

[25] One hundred and sixteen participants (116) who received IFR services have complete discharge data to allow for an analysis of the number of days of treatment. The eleven mothers who remain in treatment and have no previous completions were excluded from this analysis, for a n=105.

*With this wide range, the median better reflects the treatment picture for this group.

As seen in Table 10, the IFR program also appears to be an effective intervention in keeping mothers in treatment for a sufficient period of time to achieve long-term abstinence. Sixty-seven (64%) of mothers participated in 90 or more days of treatment, with 50 (48%) of mothers experiencing more than 120 days of treatment.

Treatment Completions

Eighty-one (56%) of IFR mothers completed one or more levels of substance abuse treatment. These 81 clients experienced a total of 120 completions. Thirty participants (37%) completed two or more separate treatment levels (e.g., a residential and an outpatient, two residential treatments, etc.).[26] Some of the completions represented continuous treatment (typically moving from a more to a less intensive level of care); others represented subsequent treatment entries (typically following a relapse).

Completion of substance abuse treatment is directly related to child safety. Seventy-eight percent (78%) of participants who completed at least one level of substance abuse treatment retained custody of their children during their participation in the IFR, as opposed to 42% of clients who entered but failed to complete treatment.

The overall temporary custody rate for IFR = 29%

Participants who lost custody of their children despite achieving at least one treatment completion experienced high numbers of treatment days (mean = 138 days; median = 137 days), but then disproportionately failed to comply with subsequent treatment recommendations, as shown below in Table 11. This data suggest that relapse continues to be a challenge to the mothers of SEI's, again reinforcing the need for longer term casework and substance abuse support.

Table 11. ***Treatment Compliance and Status. N=144***

Subsequent Compliance Level of Participants With One or More Completion	**Family Remained Intact**	**Resulted in Temporary Custody**
Complied with all subsequent treatment recommendations	66%	31%
Failed to comply with subsequent treatment recommendations	5%	38%
No additional treatment participation	29%	31%

Treatment Non-Completions

All participants who entered treatment but had neither a completion in the record nor remained in treatment (n = 33, or 23%) were considered to have failed to complete, including the five participants (3% of the total) for whom the reason for discharge is unavailable.

Days in treatment reflect the sum of all residential, intensive-outpatient, and outpatient stays by a single client, whether or not the client was discharged for non-compliance. Data on number of hours of intensive-outpatient and outpatient service remain incomplete. In future reports, the project hopes to be able to report on the intensity (hours over days) of outpatient stays of both types.

[26] Twenty-three (23) participants experienced two completions; six had three completions; one had four completions.

Of these 33 participants, 19 (58%) lost temporary custody of their children; thirteen (13) (39%) remain open to the program, including two families who reside in recovery homes;[27] and one (3%) was closed when the non-custodial father assumed custody of the children.

Of the 33 participants who entered but failed to complete treatment, nine (27%) were heroin users who did not receive methadone maintenance therapy as an adjunct to treatment

Table 12. ***Participants Receiving No Formal Treatment. N=19***

Total Number Experiencing No Formal Treatment	**19 or 13%**
Of these19:	
Number losing custody (through temporary custody)	11 or 58%
Number remaining open to program (includes one case less than 3 months old)	3 or 16%
Number closed for other reasons (private guardianship, moved out of state, death of mother)	3 or 16%
Number missing dispositional data	2 or 11%

Summary of Temporary Custody Rates

- **The overall temporary custody rate for all IFR participants = 29%**
- The overall temporary custody rate of completed clients = 21%
- The overall temporary custody rate of non-completed clients, including clients who received IFR services but did not enter formal treatment = 58%

Reduction in Drug and Alcohol Use and in Drug and Alcohol Interference in Parenting

As described further in the section *Status and Outcome Assessment*, interim outcome data show a statistically significant correlation between the length of participation in the IFR program and reductions in maternal drug and alcohol use, as well as a significant reduction in drug and alcohol interference in parenting.

Child Profile

The following child data includes information available for 156 of the 167 families receiving IFR services.

[27] Both of these mothers were heroin users who participated in abstinence-based treatment programs without the benefit of adjunct methadone maintenance therapy.

Table 13. *Children by Family. N=156*

Total Number of Children	**532**
Range per family	1-9
Mean per family	3.4
Age range of children	0-27

50% of IFR children are school age

Table 14. *Child Age Range and Percent. N=156*

Age Range	**Percent**
0-3	40%
4-6	11%
7-12	31%
13-19	15%
19 +	3%

Family size and age range of children in the home are extremely important considerations for mothers in need of substance abuse treatment. The challenges intensified by family size include finding appropriate child care for children of multiple ages while the mother is in treatment, meeting the schooling needs of older children, meeting the developmental needs of all children in the home and overcoming the effects of past inconsistent parenting. Fifty-seven (57%) percent of the children in the IFR families are ages three to 19. Approximately 50% of all children entering the project are school age.

For both intact and placement cases, the Department reports an average of 2.8 children per family; a figure that has remained between 2.5 and 3.0 for several years.[28] The IFR reports a higher figure of 3.4 children per family, which is slightly lower than the Healthy Fit average of 4.0.

Subsequent Births

Table 15. *Subsequent Pregnancies. N=167*

Total Number of Subsequent Pregnancies	**11 or 7%**
Result of pregnancies:	
Normal (not SEI) birth	4
Expecting	3
Subsequent SEI	2
Miscarriage	1
Pregnancy terminated	1

IFR mothers giving birth to a subsequent SEI =1%

Reducing the number of unplanned pregnancies among substance abusing mothers is an important way to limit the stress placed on a family and to prevent subsequent SEI births. IFR workers are required to document for each family that family planning has been addressed and that the mother has completed her six-week post-partum medical appointment. Workers have also been trained by the Chicago Department of Public Health on methods of family planning, how to talk with their clients about family planning, and how to link their clients with family planning clinics.

Only 11 (7%) of the mothers in the IFR have had subsequent pregnancies. Two of the five live births (representing 1% of all IFR mothers) have been substance exposed infants. Following the first subsequent SEI birth, the IFR revised the best practice protocol for pregnant clients. Workers must

[28] Illinois Department of Children and Family Services Division of Quality Assurance. (June 2000).

have direct contact with the woman's physician and must request more frequent urine toxicologies. (One program requirement is that mothers must agree to sign consents for sharing information with physicians.)

Paternal Involvement

The following data reflects active cases as of June 2000. Overall data has been collected on 170 fathers from IFR cases. Some data, however, is incomplete making totals for each category different.

8 of the 10 scheduled cases to be successfully closed have active paternal involvement

Table 16. ***Father's Role in Child's Life***

	At the Time of the IFR Worker's Initial Contact with Father N=128	**Currently N=97**
Father Primary Caregiver with Need for Only Occasional Help From Others	5%	6%
Father Primary Caregiver with Significant Help From Others	3%	7%
Father Secondary Caregiver with Significant Involvement	15%	12%
Father Secondary Caregiver with Low Levels or Intermittent Involvement	19%	10%
No Involvement	58%	62%
Attempting to Get Involved	0%	2%

Workers also report:

- Out of 154 identified fathers, 77 (50%) were involved in their child/ren's life prior to IFR involvement and
- An additional 13% have become involved as a result of IFR outreach.

In recognition that father involvement is often overlooked by caseworkers in child welfare, IFR has placed special emphasis on promoting paternal involvement in the project. This has been accomplished by training the IFR teams on paternal involvement issues and linking them to a community based agency focusing on fathers. Fathers are offered an array of services with early data suggesting a strong emphasis on substance abuse treatment related services.

Although data collection measures for paternal involvement are still being formalized, early figures suggest that IFR outreach can be effective. As indicated in Table 16, the father's role in the child's life as primary caregiver has increased by 5% while the father's role as secondary caregiver with low levels of involvement has decreased by 9%. In addition, 13% of fathers have become involved as a result of IFR outreach.

Court Involvement and Treatment[29]

Table 17. ***Court Involvement. N=167***

	Number	Percent
Court Involved Families	**63**	**38%**
Number resulting in Temporary Custody*	**48**	**29%**
Number issued an Order of Protection	**28**	**17%**
Of the 28 Orders of Protection:		
Number entering recommended treatment	25	89%
Number not entering recommended treatment	3	11%
Number completing recommended treatment	18	64%
Number not completing recommended treatment	10	36%
Number remaining intact	15**	54%
Number resulting in temporary custody	13	46%

*13 of these cases were issued order of protection, which resulted in temporary custody.
**In 2 of these cases, the biological father was granted custody.

When the project began, resistance to sanctions in the form of Orders of Protection mandating treatment compliance was an overriding sentiment. Most court participants and administrators expressed that if a family was in crisis enough to warrant court involvement, the result should be temporary custody. With the assistance of the State's Attorneys Office, who agreed to pilot the idea, the project began asking the court for Orders, and despite initial resistance, the court has been granting them. As seen in Table 17, 28 Orders of Protection have been granted. Of these, 89% entered the recommend treatment within 30 days before or after the Order, 64% completed the recommended treatment and more than half remain intact. Anecdotally, supervisors state that an order is the single most effective tool for treatment compliance.

Case Closings and Permanency

Table 18. ***Case Closings. N= 167***

	Families	Children
Number closed due to:		
Temporary custody	48	151
Successful completion	10*	30
Adoption/Guardianship of children	2	3
Total	**60**	**184**

*3 of 10 are officially closed; 7 are expected to close by the end of June 2000.

Considering IFR program duration is 18 to 24 months and the project has reached the 24 month point, cases that have successfully completed program requirements, including treatment recommendations, are being closed by the Department. As seen in Table 18, 10 cases are expected to be closed by the end of June 2000. Forty-eight cases (29%) have closed due to temporary custody and two cases have been closed due to adoption or guardianship of the child/ren.

Cases are officially transferred from the project to a placement team (typically within the same child welfare agency) once temporary custody has occurred. A case review of 18 of the first 30 temporary custody cases found that 3 families (7 children) have been reunified[30] and 1 family (1 child) has been

[29] Greater detail on the IFR court involved families can be found in: Office of the Inspector General (1999) *Intact Family Recovery Project: Referral, Court Involvement and Treatment Compliance as of December 31, 1999*. Chicago, IL: Office of the Inspector General.
[30] One of the three included the father gaining custody.

adopted. Of the remaining 14 families (37 children), 5 families (13) children are scheduled to return home within 12 months and in one family, one child died while in a relative placement. In families where reunification occurred or is pending, two common factors were apparent; the IFR treatment recommendations were included in the transfer summary,[31] and the mother entered treatment within 30 days of the transfer. Fifteen months was the average length of time for reunification. The reunification rate for these 18 cases is lower than the average reunification rate for DCFS and POS cases (Cook North, Central and South Regions) for FY99 (15.5% vs. 6.2%). However, these DCFS and POS figures are broad indicators including both non-drug and drug affected families. In order to have more accurate comparisons, rates should be broken down into these sub-groups.

Status and Outcome Assessment

Table 19. ***Dose Response Analysis of Primary Outcomes***

Indicator	Statistical Significance	Status
Child's Current Health Status	-.19**	Child's health improves during services
Mother's Relationship with Child	N.S.	No change during services
Parenting Skills	N.S.	No change during services
Parent Involvement in Education	N.S.	No change during services
Parent/Child Family Life	N.S.	No change during services
Safety of Parental Home	-.19**	Home becomes safer during services
Mother's Alcohol Use	.24***	Mother's drug use in better control during services
Mother's Drug Use	.24***	Mother's drinking in better control during services
Father's Involvement	N.S.	No change during services
Parent Alcohol/Drug Interference	.19**	Less alcohol/drug interference in parenting
Mother's Motivation for Sobriety	N.S.	No change during services
Mother's Denial of Problems	N.S.	No change during services
Father's Motivation for Sobriety	.13*	Trend towards improvement during services
Father's Denial	.13*	Trend towards improvement during services

*p<.1
**p<.01
***p<.001

John S. Lyons, Ph.D., Director Mental Health Services and Policy Program, Northwestern University Medical School was engaged by DCFS to evaluate the IFR project. Dr. Lyons designed a survey that is completed jointly by the child welfare and substance abuse treatment workers at time of admission and discharge and every three months in between. Dr. Lyons codes and analyzes the results and reports interim findings to the OIG. The study, *Status Outcome Assessment*, tracks workers' perceptions of the family's status on 14 items.

Dr. Lyons' has completed an interim dose response analysis the results of which are reported above. A *dose response* compares the group of parents who have just entered the program with parents who have been in the program for three months, six months, nine months, or twelve months. Dr. Lyons found statistically significant relationships between months in program and:

- Improvement in the substance exposed infant's health status,
- Increase in home safety,
- Mother's drug use in better control,
- Mother's drinking in better control and
- Less alcohol/drug interference in parenting.

Dr. Lyons found no significant relationship between months of time in program and:

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[31] Child welfare workers reported that because treatment recommendations were clear and specific, it was possible for them to quickly engage (or re-engage) the mother in treatment.

- Mother's relationship with child,
- Parenting skills,
- Parent involvement in education,
- Parent-child family life,
- Father's involvement,
- Mother's motivation for sobriety and
- Mother's denial of problems.

The interim findings of the *Status and Outcome Assessment* indicate that the IFR is accomplishing what we set out to do – to improve child safety and reduce substance abuse and its interference with parenting. It suggests that substance abuse is correlated to safety concerns. It also suggests that a reduction in substance abuse will not necessarily lead to improvements in the parent/child relationship and in parenting skills.

IV. Project Challenges and Changes in Practice

In its role as monitor, the OIG has been responsible for identifying and addressing challenges to implementation. These challenges have ranged from basic practice issues such as case transfers to more complex matters such as attempting to blend two distinct disciplines while providing services to families living in drug laden, high-risk environments. Although risk and child welfare go hand-in-hand, by pro-actively addressing challenges that arise and problem solving with the various participants involved, these risks can be minimized. The

IFR's experience has been that primary means for addressing challenges and affecting positive change has been the collection and presentation of appropriate baseline data and continuous communication with all involved parties. The following section presents some of the substantial challenges IFR has faced during the first two years of implementation and introduces some notable changes in the practice field.

Infant Mortality and Risks of Harms to Family Members Due to Drug Abuse

The IFR program received its first referrals in June 1998. In the following six months, the program experienced five deaths of infants under the age of three months. In the month of September, 2 two-month-old infants died of natural causes. The first was ruled a SIDS death. The infant was found in his crib lying on his back. The second died from congenital defects at birth. The infant never left the hospital following his birth. Two more infants died during November. A two-and-a-half month old infant girl being cared for by her grandparents was found placed on her stomach with two blankets over her. The death was ruled a SIDS. The grandfather reported smoking a pack of cigarettes a day in the house. The fourth infant's death was ruled undetermined cause and manner. The pathologist could not rule out suspicious circumstances contributing to the death.[32] The mother admitted to drinking on the day of the infant's death. The infant slept with the mother, allowing for the possibility of overlay. Public health advisors warn that a parent who is intoxicated or high from drugs who falls asleep with an infant in his/her bed may not wake up or "feel" the infant struggle if the parent rolls over the baby. The fifth infant died a natural death from pneumonia in December. The Cook County Child Death Review Team recommended immediate changes in educating parents on increased risks of infant mortality due to overlays and the practice of placing infants face down on soft bedding. The IFR staff responded to these public health concerns by educating all the IFR parents and caretakers on the *BACK TO SLEEP* protocol, providing every household with a crib, and educating caretakers on the dangers of overlay.

Approximately 30% of IFR cases enter program without adequate sleeping arrangements

[32] In this case, the mother had declined IFR services and the case was in the process of being reassigned by the Department.

Approximately 50 cribs were distributed over the next year and a half. During this time IFR infant mortalities dropped to zero. For fiscal year 2001, one death has occurred. Early reports indicate that the baby was not in a crib and was sleeping beside the mother with a pillow.

In addition to posing health risks to infants, drug and alcohol abuse compromises the health of the user. In 1999, two IFR parents died due to drug use. One mother died of a drug overdose and one father died of heart complications related to chronic heart disease and long-term heroin and cocaine use. In Chicago drug-related mortality has increased 300 percent between the years of 1980-1997. Drug overdose is one of the top five causes of death among African-Americans. Chicago drug overdoes rates have risen to a magnitude that is comparable to motor vehicle deaths.[33]

A parent's abuse of drugs or involvement in the distribution of drugs may affect safety and increase risks to family members (Herrin, 1992). Risks to the family range from accidents or harms due to lack of supervision or availability of watchful eyes to increased risk of violence due to drug lifestyles. Even if the parent is not a habitual drug user, if a member of the household is involved in drug trafficking the risk of violence to family members increases. Two of the families referred to the IFR program had death of family members due to violence related to gang retaliation and/or drug disputes. One father was murdered in the streets just prior to the family's referral to the program. The mother was shot at within days of the father's murder. The IFR staff, with the assistance of the Chicago Police Department's Youth Division transported the mother and children to the Maryville shelter to protect them from immediate harm. The mother entered the Haymarket drug treatment program and arrangements were made with non-drug involved relatives who lived outside of the community to care for the children.

In the second case, a mother was murdered in her home following a dispute with her younger half-brother whom she raised. The mother had been receiving IFR services for ten months after delivering an infant who tested positive for PCP. The mother also tested positive for PCP but denied drug use. She tested clean on random urine tests during the next ten months. She minimally cooperated with services and was reluctant to share any information about significant people in her life. Paternal relatives adopted the child after her murder.[34]

These deaths emphasize the risks to children in drug affected families, including child and parent health problems, violence, gangs, and death. They underscore the need for intense services to stop the cycle of chronic drug use, to eliminate or reduce risks and to ensure the safety of the children in the home.

Blending Disciplines

Considering that integrated child welfare and substance abuse service delivery is a paradigm shift from traditional intact services, the process of blending the disciplines has been a challenge throughout the project. Current reports refer to different perspectives and world views making cooperation and collaboration between child welfare and substance abuse service systems difficult to

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[33] Wiebel, S., Niaz, K. & Rahimian, A. (December 1999). *Patterns and Trend of Drug Abuse in Chicago.* Epidemiologic Trends in Drug Abuse:Community Epidemiology Work Group. National Institute on Drug Abuse. Chicago, IL. p. 4.

[34] Prior to delivering her baby, the mother was a foster parent and daycare provider. Her brother had a history of drug offenses and listed her address as his address each time he was arrested including during the period she was a licensed foster parent.

establish and even harder to maintain.[35] The IFR's experience has been no exception. Issues such as varying definitions of "client" (historically child welfare has viewed the child/ren as the client whereas substance abuse views the parent in treatment as the client) and "progress," became apparent obstacles early in implementation. The IFR model, however, has inherent features, including weekly joint visits and staffings and monthly cross training, that has allowed the two disciplines to constructively address and problem-solve around these differences as soon as they arise.

In addition to merging varying world views, an additional challenge has been the merging of separate and distinct administrations. This task has been more complicated. Of the original six agencies chosen to implement the project, three (two substance abuse and one child welfare) are no longer with the project. Of the remaining agencies and new agencies involved with the project, a key element appears to be continuous commitment and communication from agency administrators.

Confidentiality requirements protecting the privacy of clients in substance abuse treatment are consistently identified by both fields as a barrier to collaboration. The GAO refers to these requirements in their 1998 report as impediments for judges to obtain information about parents' progress in treatment and thus safety decision making for children.[36] Although an issue for the two fields in general, the IFR model inherently precludes the issue by requiring the parent(s) to sign consents as part of their agreement to enter into the program. Parents are informed and agree that the IFR team will share information about all aspects of the case, including substance abuse treatment. Further, both the child welfare and substance abuse workers jointly testify during any court proceedings.

Case Transfers

Once the Division of Child Protection (DCP) has completed its investigation and made the decision to keep the family intact, the case is transferred to the IFR project. This transfer, or hand-off, typically takes place in the client's home and includes the investigator, IFR team and family. According to DCP protocol, all investigations should have an in-person hand-off within 48 hours of completion.

When the IFR program began accepting referrals, in person hand-offs were occurring in approximately 30% of all cases. Not only was the frequency of face-to-face hand offs low but the content of hand-offs was an issue as well. IFR supervisors and workers reported that in those cases where an in-person hand-off did occur it was likely to consist only of "introductions". The IFR monitors and supervisors felt that hand-offs were an opportunity to openly communicate significant details of the case and fully disclose program requirements and expectations to the family. In an effort to affect procedure, the issue was brought to the attention of DCP administrators in October 1998. Improvements were immediate. As of April 1999, supervisors reported that face-to-face hand-offs have increased to 92%. Although the quality of the content has not increased as significantly as the frequency, supervisors do report improvements.

Heroin

One of the early findings in the IFR was that heroin addicted parents served by the Illinois child welfare system are rarely provided with the national standard of care for treatment of heroin

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[35] Department of Health and Human Services (April 1999). *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection.* Washington, DC: Government Printing Office. p. 6.

[36] U.S. General Accounting Office (1998). *Foster Care: Parental Substance Abuse Presents Obstacles for Securing Safe, Permanent Homes for Children.* Washington, DC: U.S. General Accounting Office. GAO/HEHS-98-182, p. 22.

addiction, i.e. methadone maintenance therapy at an appropriate dose level combined with traditional treatment. Of the first 29 mothers identified with a heroin problem, only six (21%) were provided methadone therapy. Reviews of data from other initiatives (Healthy

Fit; Family Conference; DCFS-OASA Initiative data) revealed even lower rates of methadone provision. Inadequate treatment may have serious consequences for these families. Current IFR data shows that heroin involved parents are considerably more likely to lose custody of their children during their involvement with the program (44% versus 29% overall[37])

Beginning in June 1999 and continuing to date, the OIG and DCFS Division of Health Policy began to share IFR heroin data with treatment providers, OASA leadership, Interventions staff at DCFS's Court Assessment Project, the States Attorneys Office, the Illinois Alcohol and Drug Dependence Association and the Presiding Judge of Cook County Juvenile Division. Problems identified include inadequate dose levels at many facilities, resistance to methadone by many treatment providers, ignorance of OASA guidelines which permit providers to be reimbursed both for methadone and for another level of treatment (such as intensive outpatient or residential treatment), fear of court bias against methadone use and the lack of a procedure for client informed consent which would explain the benefits and risks of methadone treatment.

Since identifying the issue, progress has been notable. Former OASA leadership committed to seeking increased methadone treatment capacity for DCFS-OASA Initiative clients for fiscal year 2001 and OASA also reports plans to educate medical directors about appropriate dose levels of methadone. IFR substance abuse partners agreed to refer heroin clients to methadone treatment. The Women's Treatment Center applied for and received permission from OASA to provide intensive outpatient treatment combined with methadone. Presiding Judge Bishop-Martin agreed to train judges on methadone. The Court Assessment Project has agreed to pilot an informed consent procedure, which the OIG will take up in the next fiscal year. Most significantly, last summer the Cook County State's Attorney applied for and received federal funding (administered by the county board) to open a family-based treatment program for intact families that would provide methadone plus treatment to heroin involved families. This program, called Project FIT (Families-In-Tact), has served nine IFR families as well as a number of other families referred by the Juvenile Court.

Public Health

In September 1997, DCFS and the Chicago Department of Public Health (CDPH) established an interagency agreement to facilitate collaboration between the agencies and provide comprehensive assessment, service planning and resource provision to families that have delivered an SEI. According to this agreement, known to the Department as APORS, within seven working days, the investigator or worker (depending on who officially has the case at this point) and public health nurse will coordinate service planning for the infant and family. In the first five months of IFR implementation, workers reported that although the seven day period had expired, approximately 40% of cases were coming into the project with no interagency coordination in place. At this time IFR administrators began working with CDPH administrators to draft IFR specific guidelines listing the purpose, policy and procedures necessary for collaboration. However since drafting these guidelines, implementation has faced programmatic obstacles including a shortage of public health nurses due to inadequate funding. Despite shortages, nurses have been assigned to assist the

IFR project. IFR supervisors report that almost every new referral has some contact with a CDPH public health nurse.

[37] Considering that the overall rate includes the heroin population, this rate excluding heroin will be even lower than the reported 29%.

The CDPH and IFR project have also joined forces to address additional health issues. Public health nurses have trained IFR supervisors and workers on how to effectively address and assist parents concerning family planning. The CDPH has also offered the services of a mobile health van that provides free immunization services to children. IFR project administrators and supervisors will continue to access public health resources while working through funding shortages.

V. Implications for the Future

At the end of fiscal year 2000, the project will have completed two full years. As it moves forward, data collection and analysis and applying lessons learned from the first two years will guide the project through year three and beyond. Particular areas of focus for year three include the following.

- **Older Siblings**

  Finding adequate childcare for school age children while the mother attends treatment is an obstacle for many IFR families, especially for those requiring residential treatment services. Although some treatment providers offer residential services for mothers and children five years and younger, none accept the older, school age children. In these cases families must make alternative arrangements for childcare that typically entails relative care. Many times due to years of addiction, the mother has exhausted all of her family members as possible caretakers. In cases where no appropriate relative care is available, the mother is unable to attend the recommended treatment.

  DCFS Division of Health Policy, Haymarket Center, Columbus Maryville and the OIG are in the process of creating an agreement that would expand options to these families. This agreement would allow the mother to enter residential treatment at the Haymarket treatment facility while the older children are placed at Columbus Maryville (an emergency reception area for children that is located near Haymarket). By merging the two programs a mother can enter the appropriate level of care, sibling groups can remain together and regular visits and interaction between mother and children can occur. The Division of Health Policy and OIG are working to finalize this agreement.

- **Parenting Program**

  As preliminary findings from the outcome assessment show significant correlations in several domains, workers, however, observe no significant improvements in the parent/child relationships and in parenting skills. These findings underscore the need for enhancement of the IFR model in the area of parenting. Over the course of year three, the project will work to integrate a parent/child educator into each IFR partnership. This educator will be responsible for assessing parenting strengths and challenges and working with the child welfare and substance abuse team to plan interventions. The program will include in-home observations and teachings to help strengthen parenting skills and a special emphasis on children's homework and family substance abuse education.

- **Family Focused Health Education**

  The project will work to develop a family focused health education program that will help inform IFR parents about general health needs and include a special emphasis on family planning options.

- **Paternal Involvement**

  The project will continue to outreach to fathers and work to provide adequate substance abuse treatment services. Possibilities for providing such services include linking with regional treatment agencies that will provide services to identified fathers.

- **Education**

  The project will focus on children's education, including ensuring that all eligible IFR children are enrolled in Head Start or state Pre-K services and exploring options for helping parents help their children improve in school.

- **Advisory Committee**

  The project will identify parents who have successfully completed the program to participate in an advisory committee. This committee will help promote the educational achievements of IFR families through the development of a mentor program.

Further, the OIG supports the belief that every substance affected child and family is entitled to the most comprehensive services possible. In an effort to meet the demand for comprehensive services, the IFR will work to ensure that the project remains at full capacity. Over the next year the project administrators will begin discussions about project expansion.

Finally, there are lessons learned in the IFR that should be applied to practice throughout the state. These include the following.

- **Case Transfers**

  Once alerted to the problems of frequency and content of DCP face-to-face case transfers, DCP administrators were able to bring the rate of face-to-face transfers to 92% for the IFR project. A future step is to determine whether or not the rate has increased system wide, and if not how to improve this increase.

- **Prevention of Overlay Deaths**

  All parents and caretakers served by DCFS and the private agencies should be educated on the *BACK TO SLEEP* protocol and the dangers of overlay. Completion of this instruction should be documented in the case file. In addition, workers should assure that every infant served by the Department has a crib.