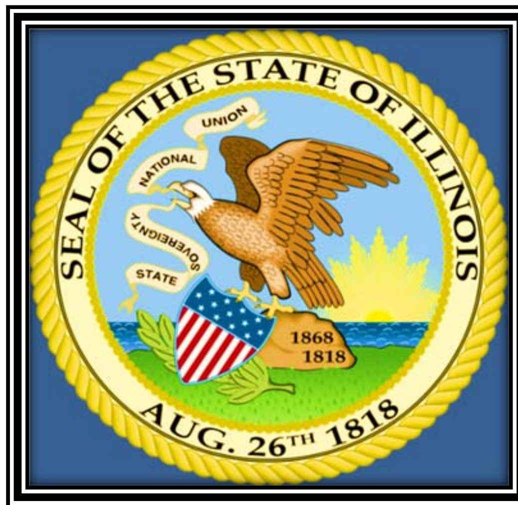
OFFICE OF THE INSPECTOR GENERAL

ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

ANNUAL REPORT TO THE GOVERNOR & THE GENERAL ASSEMBLY



JANUARY 2022

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Illinois Department of
DCFS
Children & Family Services

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

December 10, 2021

To the Governor and Members of the General Assembly:

I respectfully submit the Annual Report of the Office of the Inspector General (OIG) for the Illinois Department of Children and Family Services (DCFS).

The greatest impact of our year's work always can be found in the changes to the child welfare system effected by our systemic recommendations. Here is a snapshot of some of those changes from this past fiscal year:

1. DCFS's state central register revamped its handling of, response to, and managerial supervision relating to allegations called into its hotline of cuts, welts, and bruises to children younger than three years old.

2. DCFS established a mechanism for additional managerial review before an inexperienced, temporarily assigned child protection supervisor may approve a Child Endangerment Risk Assessment Protocol (CERAP) safety determination form that has been marked "safe," meaning no formal safety plan is needed for the child to remain in the home.

3. DCFS's planned, new Comprehensive Child Welfare Information System will include an automatic electronic notification system to notify the relevant Area Administrator of physical abuse to a child younger than three years old, so that the case can receive mandatory Area Administrator review prior to case closing. DCFS has put a temporary mechanism into place until the new system goes online.

4. DCFS filled the positions of two Indian Child Welfare Act specialists that had been left vacant for three years, ensuring better representation and services for this population of families and children.

5. Recognizing that an Administrative Law Judge's falsification of continuance orders and extensions of time in expungement cases were symptoms of larger failings, DCFS's Administrative Hearings Unit: a) developed new mechanisms for tracking pending and overdue recommended orders; and b) provided guidance to its Administrative Law Judges on streamlining their recommended orders to complete them within statutory deadlines.

As you will see in this Report, DCFS's willingness to hear and confront its shortcomings in connection with the above cases was not an aberration. For the second year in a row, DCFS's leadership has accepted and fully implemented, or committed to implementing, substantially all of our case-specific and systemic recommendations.

Our Report also notes, however, that there remains work to be done regarding the *full implementation* of prior OIG recommendations that DCFS's leadership accepted and articulated implementation plans for last year. For example, last year's Report lists numerous recommendations as old as 2011 for which DCFS acknowledges this year that full implementation is incomplete. For certain of the prior recommendations, including all of the domestic violence-related recommendations, implementation has not even meaningfully

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begun. We expect, and the families of Illinois demand, significant movement on these old recommendations in the coming year.

This year, virtually every workplace experienced COVID-19-related disruptions and scares. OIG was no exception. Through it all, my colleagues at OIG remained productive and focused on our mission and awesome responsibility to the families of Illinois. We are proud to share this summary of our sophisticated, professional, and independent work.

And to my OIG colleagues: as I tell you after every meeting, thank you for all you do.

Lester G. Bovia, Jr.
Acting Inspector General

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

TABLE OF CONTENTS

INTRODUCTION **1**

DEPARTMENT UPDATE ON PRIOR RECOMMENDATIONS **7**

INVESTIGATIONS **21**

PART I: DEATH AND SERIOUS INJURY INVESTIGATIONS 21

PART II: CHILD DEATH REPORT 49

SUMMARY 50

HOMICIDE 57

SUICIDE 67

UNDETERMINED 69

ACCIDENT 79

NATURAL 94

PENDING 118

TWENTY-YEAR DEATH RETROSPECTIVE 123

PART III: GENERAL INVESTIGATIONS 127

APPENDIX **151**

BAXTER DARBY A-1

BELLA CASTILLO ESPARZA B-1

INTRODUCTION

The Office of the Inspector General (OIG) of the Illinois Department of Children and Family Services (DCFS or Department) was created by a unanimous vote of the Illinois General Assembly in June 1993 to reform and strengthen the child welfare system. The mandate of OIG is to investigate misconduct, misfeasance, malfeasance, and violations of rules, procedures, or laws by DCFS employees, foster parents, service providers and contractors with the Department. *See* 20 ILCS 505/35.5 – 35.7. To that end, OIG conducts investigations and makes recommendations to protect children, uncover wrongdoing, improve practice, and increase professionalism within the Department.

INVESTIGATION CATEGORIES

Death and Serious Injury Investigations

OIG investigates deaths and serious injuries of Illinois children whose families were involved in the child welfare system within the preceding 12 months. The Inspector General is an *ex officio* member of the Child Death Review Team Executive Council. When the Illinois State Central Register (SCR) receives a report of child death or serious injury, a Critical Event Report is generated. OIG reviews the Critical Event Report and other computer databases to determine whether the death or serious injury meets the OIG criteria for case opening. OIG opens a case for a child death or serious injury when the family has had prior involvement with the Department, or its contracted agencies, within one year of the death or serious injury. The prior involvement includes when the child was a youth in care, the family is the subject of an open investigation or service case, or the family was the subject of a previous investigation or closed case. When further investigation is warranted, records are impounded, subpoenaed, or requested, and a review is completed. When necessary, a full investigation, including interviews, is conducted. OIG created and maintains a database of child death statistics and critical information related to child deaths in Illinois. The following chart summarizes the death cases reviewed in FY 2021:

FY 2021 CHILD DEATH CASES REVIEWED

CHILD DEATHS IN FY 2021 MEETING THE CRITERIA FOR REVIEW	**122**
INVESTIGATORY REVIEWS OF RECORDS	99
FULL INVESTIGATIONS	23

Summaries of death investigations where a full investigative report was submitted to the DCFS Director are included in the Investigations Section of this Report. Later in the same section, there are summaries of all child deaths reviewed by OIG in FY 2021.

General Investigations

OIG responds to and investigates complaints filed by the state and local judiciary, Department and private agency employees, foster parents, biological parents and the general public. Investigations yield both case-specific recommendations, including disciplinary recommendations, and recommendations for systemic changes within the child welfare system. OIG monitors compliance with all recommendations.

Child Welfare Employee Licensure Investigations

In 2000, the General Assembly mandated that the Department institute a system for licensing direct service child welfare employees. The Child Welfare Employee License (CWEL) permits centralized credentialing and monitoring of all persons providing direct child welfare services,

whether they are employed with the Department or a private agency. The employee licensing system seeks to maintain accountability, integrity, and honesty of those entrusted with the care of vulnerable children and families.

A CWEL is required for Department and private agency investigative, child welfare, and licensing workers and supervisors. The Department, through the Office of Employee Licensure, administers and issues CWELs.

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

When a CWEL investigation is completed, OIG, as the Department's representative, determines whether the findings of the investigation support possible licensure action. Such allegations that could support licensure action include conviction for specified criminal acts, indicated findings of child abuse or neglect, or egregious acts that demonstrate incompetence or a pattern of deviation from a minimum standard of child welfare practice. Department Rule 412.50 (89 Ill. Adm. Code 412.50) specifies the grounds for licensure action. When licensure action is appropriate, the licensee is provided an opportunity for a hearing. An Administrative Law Judge presides over the hearing and reports findings and recommendations to the CWEL Board. The CWEL Board makes the final decision regarding licensure action.

In FY 2021, 18 cases were referred to OIG for CWEL investigations.

FY 2021 CWEL INVESTIGATION DISPOSITIONS

FY 2021 CWEL INVESTIGATIONS	**18**
PENDING INVESTIGATIONS	6
LICENSE RELINQUISHED	9
PENDING ADMINISTRATIVE HEARING	1
PENDING WITH CWEL BOARD	2

Criminal Background Investigation and Law Enforcement Liaison

The Department is required by statute to assess the relevant criminal history of caretakers prior to the placement of children and to accomplish its other statutory duties. (20 ILCS 505/5(v)). Because OIG meets the definition of a criminal justice agency in the Department of Justice Regulations on Criminal Justice Information Systems (Title 28, Code of Federal Regulations, Part 20, Subpart A) OIG, unlike the Department, has access to criminal history outside of Illinois within limits set by the National Crime Prevention and Privacy Act. The Law Enforcement Agencies Data System (LEADS), as dictated by state and federal law, cannot be used to conduct background checks for employment or licensing purposes. The Illinois Administrative Code forbids use of the LEADS network and LEADS data for personal purposes. OIG provides technical assistance to the Department and private agencies in performing and assessing out of state criminal history checks for the purpose of child safety in emergency placement. OIG answers case requests for criminal background information from LEADS. Each case may involve multiple law enforcement database searches and may involve requests on multiple persons. Though LEADS results may be used immediately, fingerprint checks are required for confirmation.

In addition to child protection investigator and caseworker requests, when the Placement Clearance Desk is considering a non-licensed home for placement and the Illinois LEADS contains an arrest which may pose a safety threat to a child, but there is no disposition information, OIG provides technical assistance in obtaining

the disposition. The Placement Clearance Desk may also request an out-of-state LEADS check for approving a home for immediate placement of children.

In FY 2021, OIG conducted over 6,000 searches for criminal background information.

In addition, in the course of an investigation, if evidence indicates that a criminal act may have been committed, OIG may notify the Illinois State Police. OIG may also investigate the alleged act for administrative action only.

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

Referrals from the Office of the Executive Inspector General

In FY 2021, OIG received 69 referrals for investigation from the Office of the Executive Inspector General. After initial review, a referral may be closed, opened for further investigation, or transferred for further review by Department management, the Office of Affirmative Action, Labor Relations, or the Advocacy Office.

INVESTIGATIVE PROCESS

OIG's investigative process begins with a Request for Investigation, notification by the State Central Register of a child's death or serious injury, or a referral for a CWEL investigation. Investigations may also be initiated when OIG learns of a pending criminal or child abuse investigation against a child welfare employee.

In FY 2021, OIG received 4,821 Requests for Investigation or technical assistance.[1] Requests for Investigation and notices of deaths or serious injuries are screened to determine whether the facts suggest possible misconduct by a foster parent, Department employee, or private agency employee, or a need for systemic change. If an allegation is accepted for investigation, OIG will review records and interview relevant witnesses. The Inspector General reports to the Director of the Department and to the Governor with recommendations for discipline, systemic change, or sanctions against private agencies. OIG monitors the implementation of accepted recommendations.

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

OIG is mandated by statute to be separate from the operations of the Department. OIG files are not accessible to the Department. The investigations, investigative reports, and recommendations are prepared without editorial input from either the Department or any private agency. Once a report is completed, OIG will consider comments received and the report may be revised accordingly.

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

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

Administrative Rules

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

Confidentiality

A complainant to OIG, or anyone providing information, may request that their identity be kept confidential. To protect the confidentiality of the complainant, OIG will attempt to procure evidence through other means, whenever possible. At the same time, an accused employee needs to have sufficient information to enable that employee to present a defense. 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 OIG.

Reports issued by OIG contain information that is confidential pursuant to both state and federal laws. As such, OIG reports are not subject to the Freedom of Information Act. Annually, OIG prepares several reports redacting confidential information for use as teaching tools for private agency and Department employees.

Impounding

OIG is charged with investigating misconduct "in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution." 20 ILCS 505/35.5(b). In order to conduct thorough investigations, while at the same time ensuring the integrity of records, OIG investigators may impound files by immediately securing and retrieving original records. When files are impounded, a receipt for impounded files is left with the office or agency from which the files are retrieved. Critical information necessary for ongoing service provision may be copied during the impound, in the presence of an OIG investigator. Impounded files are returned as soon as practicable.

REPORTS

OIG reports are submitted to the Director of DCFS. Specific reports also are shared with the Governor. An OIG report contains a summary of the complaint, a historical perspective on the case, including a case history, and detailed information about prior DCFS or private agency contact(s) with the family. Reports also include an analysis of the findings, along with recommendations.

OIG uses some reports as training tools to provide a venue for ethical discussion on individual and systemic problems in child welfare practice. The reports are redacted to ensure confidentiality and then distributed to the Department or private agencies as a resource for child welfare professionals. Redacted reports are available on the OIG website or by calling OIG at (312) 433-3000.

Recommendations

OIG may recommend systemic reform or case-specific interventions in the investigative reports. Systemic recommendations are designed to strengthen the child welfare system to better serve children and families.

Ideally, discipline should have an accountability component as well as a constructive or didactic one. It should educate an employee on matters related to his/her misconduct while also functioning to hold employees responsible for their conduct. 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.

OIG presents recommendations for discipline to the Director of the Department and, if applicable, to the director and board of the involved private agency. Recommendations for discipline may be subject to due process requirements. In addition, 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, OIG may investigate further to

determine appropriate recommendations for systemic reform.

When recommendations concern a private agency, appropriate sections of the report are submitted to the agency director and the board of directors of that agency. The agency may submit a response. In addition, the board and agency director are given an opportunity to meet with OIG to discuss the report and recommendations.

OIG is a small office in relation to the child welfare system. Rather than address problems in isolation, OIG views its mandate as strengthening the ability of the Department and private agencies to perform their duties.

OIG monitors implementation of recommendations made to the Director of DCFS and private agencies. Monitoring may take several forms. OIG will monitor to ensure that Department or private agency staff implement the recommendations made. OIG may consult with the Department or private agency to assist in the implementation process. OIG may also develop accepted reform initiatives for future integration into the Department.

OIG HOTLINE

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

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

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

The following chart summarizes OIG's response to calls received in FY 2021.

CALLS TO OIG HOTLINE IN FY 2021

TOTAL CALLS	599
INFORMATION AND REFERRAL	364
REFERRED TO SCR HOTLINE	70
REQUEST FOR OIG INVESTIGATION	165

DEPARTMENT UPDATE ON PRIOR RECOMMENDATIONS

The following systemic recommendations were issued to the Department in prior fiscal years and were pending at the issuance of last year's Annual Report. The Department's current implementation status of these recommendations is detailed below in the following categories:

- **CHILD PROTECTION**
- **DOMESTIC VIOLENCE**
- **FOSTER HOME LICENSING**
- **INFORMATION TECHNOLOGY**
- **INTACT FAMILY SERVICES**
- **PERSONNEL**
- **SERVICES**

CHILD PROTECTION

FY 2020

The Department should develop a statewide training with Child Protection Staff and DCFS Legal around the availability and use of the three types of court supervision orders (from OIG FY 2020 Annual Report, Death and Serious Injury Investigation 1).

FY 2021 Department Update: The Office of Legal Services and Operations have worked collaboratively with the Administrative Office of the Illinois Courts (AOIC) and other court stakeholders to develop training that was presented in December 2021. The training addresses intact family services cases and the orders that are available to the court. In addition, the Office of Legal Services and Operations have collaborated with the AOIC and court stakeholders to develop a reference guide for use by the court and stakeholders as to what an intact case is; the reasons why a case may be referred to intact family services; how the case may be referred to court; and the types of court orders that the court can utilize. Further, the Office of Legal Services and Operations have worked collaboratively with the AOIC and court stakeholders to draft a memo that summarizes various legal issues related to protective custody, urgent and immediate necessity, and the use of safety plans. The memo will be utilized to develop further training for child protection and other DCFS staff.

FY 2020

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

FY 2020 Department Update: The Department plans to write a practice memo to the field on blatant disregard and its application on neglect allegations. The recommendation will also be addressed through training.

FY 2021 Department Update: The practice memo is currently being drafted by Child Protection and will be shared with the Office of Learning and Professional Development and will be incorporated in Department of Child Protection Foundations Training.

FY 2019
Child protection staff should be required to utilize the CFS 968-90, *Questions for Mental Health Professionals,* when interviewing mental health professionals regarding an alleged perpetrator (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 2).

FY 2020 Department Update: The Department agrees and will revise the form to be utilized as an investigative tool for child protection.

FY 2021 Department Update: The Department agrees and will collaborate with the Clinical Division for revisions to the form to be used as an investigative tool in child protection investigations.

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

FY 2020 Department Update: The recommendation has been incorporated in the draft of Procedures 300, *Reports of Child Abuse and Neglect*.

FY 2021 Department Update: The recommendation has been incorporated in the draft of Procedures 300, *Reports of Child Abuse and Neglect*

FY 2019
The SACWIS version of the Adult Substance Abuse Form should be amended so that the collateral section cannot be bypassed without a waiver. The waiver should only be given if there is no indication of substance abuse (from OIG FY 2019 Annual Report, General Investigations 6).

FY 2020 Department Update: Child Protection Administrators will work with staff from the Department of Information Technology to implement this recommendation.

FY 2021 Department Update: Child Protection Administrators will work with staff from the Department of Information Technology to implement this recommendation.

FY 2019
The Department should consider adding an alternative on the Child Endangerment Risk Assessment Protocol (CERAP) to allow a finding of "conditionally safe" – identifying factors where if there is a change in circumstances court intervention may be warranted (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 2).

FY 2021 Department Update: After thorough review and evaluation, with the support of our partners at Chapin Hall, the Department has selected a new Safety Decision tool to replace the Child Endangerment Risk Assessment (CERAP) and the implementation planning is underway.

The model involves multiple assessments of child safety throughout the life of the child welfare case, moving seamlessly from child protection into ongoing services. The Department agrees that a child can be determined to be safe only under certain conditions, and that if those conditions are removed, a new assessment must immediately occur which may result in the decision to take protective custody or request juvenile court intervention. The new Safety Decision Tool, developed by child welfare experts, does not include a finding in the assessment of safety as conditionally safe. It means that if a child is only safe under certain conditions, that assessment may be a finding of: 1.) SAFE because the protective capacity of the parent effectively controls and manages the safety threat in the home or 2.) UNSAFE because there is impending danger or threat and the parent/caretaker does not have sufficient protective capacity to effectively control and manage the danger. In number two, the child must be either brought into DCFS custody or a short-term voluntary parent signed safety plan.

FY 2019

The Department should evaluate the current Child Welfare Services referral system for efficacy and responsiveness. The evaluation should include reviewing timeframes for a CERAP, a response time frame, and service provision time frames and determine needed improvements (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 7).

FY 2021 Department Update: House Bill 1551 went into effect in January 2020 which expanded the criteria to qualify for an intake Child Welfare Services (CWS) referral. This created an increase in the volume of cases being referred. Due to the increase, the CWS program was identified as needing to be a standalone program. The determination was made to privatize the CWS program. This occurred on July 1, 2021. The program plan was developed in collaboration with intact purchase of service agencies and Family Advocacy Centers who would be providing this service. Input was also provided by DCFS Intact division, DCFS contracts and DCFS finance. The program plan clearly outlines the roles and expectations and was utilized to incorporate changes in both Procedures 300, *Reports of Child Abuse and Neglect* and Procedures 304, *Access to and Eligibility for Child Welfare Services*, which are currently under review. Currently there are 4 agencies receiving intakes covering 29 counties throughout the state of Illinois. The Department will issue a policy update to the field to communicates CWS procedures.

FY 2010

Child protection managers should track and maintain data on cases presented to the State's Attorney's Office for filing of petitions and the State's Attorney's Office's response. Child protection offices should share this information with DCFS Office of Legal Services (from OIG FY 10 Annual Report, Death and Serious Injury Investigation 7).

FY 2021 Department Update: The Office of Legal Services is working collaboratively with the Department of Child Protection to track referrals to the State's Attorney Office for the filing of petitions and the outcomes. As of July 2021, the Department of Child Protection began measuring and tracking referrals to the State's Attorney for juvenile court intervention on every investigation. In order to close an investigation in SACWIS, child protection investigators are required to select, through a drop-down menu, whether or not the case was screened in juvenile court and the outcome.

FY 2005

The Child Endangerment Risk Assessment Protocol (CERAP) should be amended to require that workers note when a risk factor cannot be answered because of insufficient information. Under such circumstances, workers should be required to perform diligent inquiry into relevant facts for assessment within 48 hours. The Department should develop procedures to ensure that there is follow-up and resolution of unknown variables (from OIG FY 05 Annual Report, Death and Serious Injury Investigation 9).

> *FY 2021 Department Update:* The Department has selected a new safety decision tool to replace the Child Endangerment Risk Assessment Protocol (CERAP) and the implementation planning is underway.

DOMESTIC VIOLENCE

FY 2019

In cases of violence and risk of violence, the Child Endangerment Risk Assessment Protocol (CERAP) should include an assessment of the custodial parents' protective capacity, which could change as new facts are learned. In this case, had the mother's protective capacity been noted as positive because of her decision to get an order of protection, backtracking on that decision warranted a reexamination of her protective capacity (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 5).

> *FY 2021 Department Update:* After thorough review and evaluation, with the support of our partners at Chapin Hall, the Department has selected a new Safety Decision tool to replace the Child Endangerment Risk Assessment Protocol and the implementation planning is underway. The model involves multiple assessments of child safety throughout the life of the child welfare case, moving seamlessly from the child protection into ongoing services. It supports change-focused case planning, ongoing safety management, and timely reunification and/or case closure when children are in safe, permanent homes.

FY 2016

In cases of severe domestic violence, Department procedures should require safety plans that include the involvement of shelter staff or other family support agreeing to contact the Department if the family leaves the shelter (from OIG FY 16 Annual Report, General Investigation 4).

> *FY 2020 Department Update:* The use of safety plans in cases of domestic violence has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*
>
> *FY 2021 Department Update:* Procedures 300 Appendix J, *Domestic Violence* is being published for Proposed Policy Review no later than December 20, 2021.

FY 2015

The Department should develop guidelines identifying behavior that calls into question the protective capacity of a non-offending caretaker. When protective capacity issues are identified, the Department must review available records and conduct a clinical interview to assess protective capacity. Recommendations from the Assessment must be included in any service plan (from OIG FY 2015 Annual Report, Death and Serious Investigation 3).

FY 2020 Department Update: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*

FY 2021 Department Update: Procedures 300 Appendix J, *Domestic Violence* is being published for Proposed Policy Review no later than December 20, 2021.

FY 2012
The Department should examine the continued utility of the Domestic Violence Screen and determine whether the Screen assists in assessing safety and risk to children (from OIG FY 2012 Annual Report, General Investigations 1).

FY 2020 Department Update: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*

FY 2021 Department Update: Procedures 300 Appendix J, *Domestic Violence* is being published for Proposed Policy Review no later than December 20, 2021.

FY 2012
The Department should consider requesting the assistance of Child Advocacy Centers (CAC) to interview children in investigations where there is chronic violence in the home and parents have failed in the past to cooperate with services (from OIG FY 2012 Annual Report, General Investigations 1).

FY 2020 Department Update: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*

FY 2021 Department Update: Procedures 300 Appendix J, *Domestic Violence* is being published for Proposed Policy Review no later than December 20, 2021.

FY 2012
Policy Transmittal 2010.23, which issues revisions to Procedures 302.260, *Domestic Violence Practice Guide*, and Procedures 300, Appendix J: *Domestic Violence*, allows for batterers to remain in the home with a domestic violence safety plan. This policy should be amended to clarify that when domestic violence has occurred in the home, it is presumed that the home environment is too dangerous for the child to remain, unless the perpetrator of violence is out of the home. Policy Transmittal 2010.23 should make clear that establishing a domestic violence safety plan for children should not preclude taking protective custody (from OIG FY 2012 Annual Report, General Investigations 1).

FY 2020 Department Update: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*

FY 2021 Department Update: Procedures 300 Appendix J, *Domestic Violence* is being published for Proposed Policy Review no later than December 20, 2021.

FY 2011

The Department's Domestic Violence Protocol should be revised to address the cumulative effect of domestic violence and strategies for addressing cases of chaotic family life in which the victim/abuser dynamic results in an incalculable emotional toll to the children, including collaboration with DCFS Clinical and the Office of Legal Services (from OIG FY 2011 Annual Report, Death and Serious Injury Investigation 11).

> *FY 2020 Department Update*: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*
>
> *FY 2021 Department Update:* Procedures 300 Appendix J, *Domestic Violence* is being published for Proposed Policy Review no later than December 20, 2021.

FY 2011

The Department should integrate into its domestic violence protocol the need for increased scrutiny and heightened risk when a person suspected of being a victim of domestic violence has provided false information to protect an abuser of his or her child (from OIG FY 2011 Annual Report, Death and Serious Injury Investigation 12).

> *FY 2020 Department Update*: The recommendation has been incorporated in draft Procedures 300 Appendix J, *Domestic Violence.*
>
> *FY 2021 Department Update:* Procedures 300 Appendix J, *Domestic Violence* is being published for Proposed Policy Review no later than December 20, 2021.

FOSTER HOME LICENSING

FY 2020

The Department should issue a policy memo clarifying the process for determining foster home capacity based on Rule 402, *Licensing Standards for Foster Family Homes*, Appendix C and should be consistent with placement clearance desk procedures (from OIG FY 2020 Annual Report, Death and Serious Investigation 7).

> *FY 2020 Department Update:* The expanded capacity chart and narrative explanation for how to calculate expanded capacity shall be developed and issued through an information transmittal. In addition, the document shall be shared via e-mail with all DCFS and POS agency child welfare and licensing supervisors and administrators, as well as DCFS child protection staff. Direction will be provided to fully discuss the expanded capacity document at the next staff/team meeting and ensure that staff understand how to calculate capacity.
>
> *FY 2021 Department Update:* A policy memo clarifying the process for determining capacity will be issued by December 31, 2021.

FY 2020

The Department should reconsider and clarify procedures for any language testing for Spanish-speaking foster parents. The 2019 protocol provides that licensing workers will be administering verbal tests to all foster parents with Spanish-speaking foster children. Unless the Department

establishes a standard of fluency, this provision may result in grading disparities like those identified in employee-certification testing (from OIG FY 2020 Annual Report, General Investigations 11).

FY 2021 Department Update: A policy proposal was drafted and submitted to the Office of Child and Family Policy to finalize a process for foster home licensing staff to designate a foster home as a Spanish-speaking home, however, the Department is in the process of determining what staff persons should be authorized to make this determination.

FY 2010
The Department should amend Procedures 301, Appendix E, *Placement Clearance Process*, to provide guidelines for the monitoring and resolution of involuntary placement holds. These guidelines should include instructions for requesting the removal of an involuntary placement hold. The guidelines should also require that when an involuntary placement hold is placed on a foster home, the licensing worker and licensing supervisor should re-evaluate the placement hold every six months (from OIG FY 2010 Annual Report, General Investigation 4).

FY 2021 Department Update: The recommendation was incorporated in procedures and released via Policy Transmittal 2021.09-Procedures 301.Appendix E, *Placement Clearance Process* on November 5, 2021.

INFORMATION TECHNOLOGY

FY 2020
DCFS should ensure that the new Comprehensive Child Welfare Information System (CCWIS) has an indicator to alert State Central Register staff when a subject in a Hotline report has had their parental rights terminated. In the interim, this indicator should be added to the existing SACWIS system (from OIG FY 2020 Annual Report, General Investigations 2).

FY 2021 Department Update: The Department is in the procurement process for the new Comprehensive Child Welfare Information System (CCWIS) and has submitted a request to the Department of Technology and Innovation to ensure a new flag is set when a subject in a Hotline report has had their parental rights terminated as part of the new solution.

FY 2020
With the development of the new Comprehensive Child Welfare Information System (CCWIS) program the Department should request that the program be able to track the CANTS and LEADS searches of individual users (from OIG FY 2020 Annual Report, General Investigations 3).

FY 2021 Department Update: The Department is in the procurement process as it relates to developing a Comprehensive Child Welfare Information System (CCWIS). The Department will request that CCWIS be able to track CANTs and LEADs searches of individual users.

FY 2020
The Department should ensure that SACWIS and/or the new Comprehensive Child Welfare Information System (CCWIS) has all previous history of individuals linked to that person and

accessible from clicking on the person's name (from OIG FY 2020 Annual Report, General Investigations 4).

> *FY 2021 Department Update:* The Department will ensure that as part of the Comprehensive Child Welfare Information System (CCWIS) implementation that this data integration will be part of system migration.

FY 2011

HealthWorks should obtain the results of newborn genetic metabolic screens on all children, regardless of their age, upon entering Department care. If the results of the genetic screen are unavailable, the Department should ensure that the screen is completed during the HealthWorks comprehensive exam or by the child's primary care physician (from OIG FY 2011 Annual Report, Death and Serious Injury Investigation 9).

> *FY 2020 Department Update:* Illinois Department of Public Health is currently sending the new fields to the Office of Information Technology Services. Additional birth data fields include birth weight, gestational age, Apgar Score 5, Apgar Score 10, plurality, birth order, abnormal conditions, and congenital abnormalities. The newborn metabolic screening is not complete. The Office of Information Technology Services plans to incorporate the newborn metabolic screening into SACWIS in June 2021.
>
> *FY 2021 Department Update:* The Department will ensure that as part of the Comprehensive Child Welfare Information System (CCWIS) implementation that newborn genetic metabolic screens be included.

INTACT FAMILY SERVICES

FY 2019

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

> *FY 2021 Department Update:* Intact family services staff are required to make a nursing referral within 30 days of case opening. Due to the shortage of DCFS Nurses, the nurse will be consulted throughout the case opening and utilized where feasible. The Intact Worker will: Within one week of case opening, convene a phone conference with the assigned DCFS Regional Nurse, if there is already one assigned, and the referral is still open; or make the appropriate referral to have a DCFS Regional Nurse assigned. This information was presented at Statewide Intact Provider Meetings. A copy of the presentation was also attached to the Outlook meeting invite and distributed to all participants. The presentation was also sent to all agencies involved in the Child Welfare Advisory Council. In addition, the information was communicated to staff at an all staff intact meeting on March 8, 2021.

FY 2019

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

> *FY 2021 Department Update:* The recommendation was incorporated in Policy Guide 2020.16, *Intact Family Services* and issued on November 20, 2020. Procedures 302.388, *Intact Family Services*, is being revised to reflect that the worker must request that the family sign consents for release of information for all known medical providers at the transitional visit.

FY 2019 and FY 2017

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

> *FY 2021 Department Update:* Intact family services staff are required to make a nursing referral within 30 days of case opening. Due to the shortage of DCFS Nurses, the nurse will be consulted throughout the case opening and utilized where feasible. The Intact Worker will: Within one week of case opening, convene a phone conference with the assigned DCFS Regional Nurse, if there is already one assigned, and the referral is still open; or make the appropriate referral to have a DCFS Regional Nurse assigned. This information was presented at Statewide Intact Provider Meetings. A copy of the presentation was also attached to the Outlook meeting invite and distributed to all participants. The presentation was also sent to all agencies involved in the Child Welfare Advisory Council. In addition, the information was communicated to staff at an all staff intact meeting on March 8, 2021.

FY 2018

The Department should explore expanding the Child Welfare Training Academy Simulation residential home for intact family workers and supervisors (from OIG FY 18 Annual Report, Death and Serious Investigation 1).

> *FY 2021 Department Update:* The impact of the COVID-19 pandemic and rate of staff turnover slowed the expansion of simulations for FY21 and into FY22, however, contracts for simulation centers in Dekalb and Carbondale are in the process of being finalized and once implemented, intact will be the priority population for the new simulation centers.

PERSONNEL

FY 2020

DCFS should develop guidelines, training, and Rules applicable to child welfare staff considering adoption of a child from a family that the staff (DCFS or private agency) had professional involvement with. The guidelines should contain the following elements: 1) ensuring the involvement of a neutral third-party adoption agency as the decision maker; 2) advising that staff should not

approach former clients directly or with current workers, because there is too much risk of role confusion or inadvertent coercion; and 3) advising that staff should respect former clients' privacy and not use their contact information for personal reasons (from OIG FY 2020 Annual Report, General Investigation 13).

FY21 Department Update: The Department agrees with this recommendation and has begun the process to amend Department Rules and Procedures to address circumstances where Department or private agency staff are considering adopting a child from a family with whom staff had professional involvement. The Department intends to model any recommended changes to Rule 401.540, *Preferential Treatment in Child Placement*, after the requirements in DCFS Rule 437, *Employee Conflict of Interest*. The Department is also considering amendments to DCFS Rule 402, *Licensing Standards for Foster Family Homes*, on foster home licensing, since Rule 402 relates to private agency workers and similar conflict issues that exist for DCFS employees who become licensed foster parents.

FY 2020

To reiterate recommendations made in the Confidential Memorandum dated September 9, 2019 regarding state issued equipment for employees on desk duty or administrative leave—in order to ensure a thorough investigation into allegations of employee misconduct: (a). DCFS should immediately develop a protocol on how and when electronic devices are retrieved from employees during an investigation of misconduct of that employee. All supervisors, including Area Administrators, Regionals Administrators, and Public Service Administrator's should be informed about the procedure and when the procedure should be utilized. (b). At the earliest indication that an employee will be placed on administrative leave or desk duty their DCFS-issued electronic devices should be retrieved from the employee's possession. The items should be taken before the employee is informed that their duties have been reduced (from OIG FY 2020 Annual Report, General Investigation 12).

FY 2021 Department Update: When an employee is placed on desk duty the supervisor provides a memo to the employee explaining the duties when on desk duty. The supervisor makes a determination as to the level of information technology (IT) access dependent on the reason for desk duty. In the event an employee is placed on administrative leave the administrative leave protocol states that the employee is required to turn over electronic equipment (i.e. phone, computer). The administrative leave protocol also instructs the manager to collect the IT equipment.

FY 2019

The involved private agency should reimburse the Department for all costs associated with toxicology screens that were conducted for a father as part of his service plan despite no history of drug use and continued negative toxicology screens (from OIG FY 2019 Annual Report, General Investigation 3).

FY 2020 Department Update: The Department plans to gather client information related to the toxicology requests/service delivery imposed on said client. The Department will work with the private agency to obtain payment of toxicology services, dating back to 2009.

FY 2021 Department Update: The Department plans to gather client information related to the toxicology requests/service delivery imposed on said client.

FY 2019

The issue as to what a child welfare professional can or cannot do in advising non-professionals (i.e. providing expert advice to a friend) should be referred to the Ethics Officer for a determination as to what is permitted or not permitted to be discussed (from OIG FY 2019 Annual Report, General Investigation 18).

FY 2021 Department Update: The DCFS Ethics Officer developed a training related to this issue as well as conflicts of interest, the Code of Ethics for Child Welfare Professionals, DCFS Rule 431, *Confidentiality of Personal Information of Persons Served by DCFS* and DCFS Rule 437, *Employee Ethics and Conflict of Interest.* This training was given via WebEx to case workers and investigative staff.

FY 2019

The Department should create a timekeeping process with a form separate from timesheets to formalize and document temporary assignments (from OIG FY 2019 Annual Report, General Investigation 16).

FY 2020 Department Update: In February 2020 DCFS Payroll became a participant in the IL Acts ERP Program HCM Project. This new timekeeping platform is projected to improve efficiency, enable statewide transparency for both timekeeping and payroll processes, and will include temporary assignment approval/tracking. The Department also developed a new Temporary Assignment form that has been submitted to the Office of Child and Family Policy for approval.

FY 2021 Department Update: DCFS is still an active participant in the ERP/Human Capital Management Project which will implement a new timekeeping/payroll system. The Department expects this functionality to exist in the new system. The full system implementation was initially planned for December 2021, however rescheduled to the first half of 2022. For this reason, the Department is finalizing the paper form to utilize in the interim.

SERVICES

FY 2019

The Department should develop transition procedures and interagency collaboration similar to Procedures 302, Appendix N, *Transition Planning for Wards with Developmental Disabilities*, for pregnant and parenting youth in care with significant mental illness who are aging out of care. Policy Transmittal 99.14 discusses creating interagency agreements, which might also be helpful with this population (from OIG FY 2019 Annual Report, Death and Serious Injury Investigation 3).

FY 2021 Department Update: On April 1, 2020, DCFS released revised Procedures 302, Appendix J, *Rights, Standards, and Best Practices for Pregnant and Parenting Youth,* that includes descriptions of the Parenting Assessment Team and Parental Capacity Evaluation as available assessments for parenting youth with mental health problems. These assessments provide recommendations for services and identify resources that are provided to the permanency team for service planning. The Teen Parent Service Network's Clinical team provides clinical consultation/staffing and discharge planning meetings for parenting youth with mental health problems and includes referrals/resources for community based mental health services. In addition, DCFS maintains a contract for a Transitional Living Program (TLP) for parenting youth with

mental health problems. The TLP maintains a continuum of care of services that includes access to DHS services post discharge from care. The Longitudinal Data System- Intergovernmental Agreement has been signed by the Director. The data sharing agreements for the remaining agencies are still under development. The Office of Education and Transition Services will convene an internal meeting with the Office of Legal Services, Operations, Child and Family Policy, Guardian's Office and Clinical to discuss the development of an intergovernmental agreement to address the needs of transitioning pregnant and parenting teens with mental health disorders that will mirror the intergovernmental agreement that exists for youth in care that are developmentally disabled and transitioning out of care.

FY 2019

The Department should create clear procedures for workers to have when confronted with an issue pertaining to the ever-growing field of electronic access to school records, particularly when the Department has custody and guardianship of a minor. Caseworkers should have clear direction as to when it would be appropriate to request a non-custodial parent's access be denied or restricted to school records. Further, the Department should determine whether caseworkers should request that the access be restricted from the school or through a court order. This should be developed in consultation with school districts and/or the Illinois State Board of Education (from OIG FY 2019 Annual Report, General Investigations 13).

FY 2020 Department Update: The Department continues to engage in discussions with the Illinois State Board of Education and local school districts to develop a policy that will address this issue. Given the complexity of this issue and the number of school districts in the State, this will be an ongoing process.

FY 2021 Department Update: The Department continues to engage in discussions with the Illinois State Board of Education and local school districts to develop a policy that will address shared challenges. The Office of Education and Transition Services will reach out to the Office of Legal Services, Child and Family Policy and Operations to convene an internal meeting to determine whether caseworkers should request that non-custodial parent's access be denied or restricted to school records, and if the restriction or denial should be through the school or a court order.

FY 2019

All placement supervisors and caseworkers must be trained on Policy Guide 2019.04, *Requirements for Reunification and After Care Services* (from OIG FY 2019 Annual Report, Death and Serious Investigation 1).

FY 2020 Department Update: A training will be developed in FY 2021 for permanency supervisors. This recommendation will be incorporated in the training for supervisors on content regarding reunification and after care services. Supervisors will then train staff in supervision and in team meetings on this issue. Agency Performance Team staff will also be included to train private agency supervisors.

FY 2021 Department Update: The Office of Learning and Professional Development and Permanency leadership began meeting in November 2021 to collaborate on training regarding reunification planning and to identify subject matter experts in Permanency to develop additional in-service curricula to be implemented by the field. The training is anticipated to roll out in the spring of 2022.

FY 2018

The Department should conduct an audit of split custody cases (i.e. cases in which some of the children are in state care and some are at home). A review should determine if the children at home need more intensive services (from OIG FY 18 Annual Report, Death and Serious Investigation 4).

FY 2021 Department Update: The Division of Quality Enhancement completed a review of a sample of 153 split custody cases (i.e. cases in which some of the children are in state care and some are at home with no DCFS legal custody or guardianship). Several themes were identified throughout the review. Findings of whether service intensity adequately met service needs was limited due to minimal case note documentation in SACWIS that discussed the Children in the Home of Origin and whether assessment for service had been completed. Findings were as follows: 1) Caseworkers need to be mindful in correctly identifying and adding children in the home of origin to the 1410-registration/case opening form and 2) Areas for improvement is the consistent in-person monthly contact with children in the home of origin, assessment for service needs and providing service referrals to address identified needs.

FY 2017

The Department should develop a policy for accessing publicly posted social media for information relevant to investigative, intact and/or placement cases (from OIG FY 2017 Annual Report, General Investigations 4).

FY 2020 Department Update: The current administration agrees with the recommendation and believes social media can be useful while investigating or providing casework. DCFS will continue to explore options for allowing investigators and caseworkers to access social media as part of their practice without violating Illinois Department of Innovations and Technology's policies.

FY 2021 Department Update: The current administration agrees with the recommendation and believes social media can be useful while investigating or providing casework. The Department will continue to explore options for allowing investigators and caseworkers to access social media as part of their practice without violating Illinois Department of Innovations and Technology's policies.

FY 2017

Prior to return home, caseworkers must develop a reunification plan that identifies basic necessities that must be in place before return home (food, beds, diapers, etc.); support services that must be in place before return home (homemaker, visiting nurse, counseling, early intervention, Head Start, day care, school, respite care, etc.); and community resources appropriate and available within two miles of the family's home (WIC, food pantry, local library, etc.). The Department must ensure that the family is securely anchored to supportive services (from OIG FY 2017 Annual Report, Death and Serious Injury Investigation 2).

FY 2020 Department Update: The recommendation will be incorporated in training planned for permanency supervisors in fiscal year 2021.

FY 2021 Department Update: The Office of Learning and Professional Development and Permanency leadership began meeting in November 2021 to collaborate on training regarding reunification planning and to identify subject matter experts in Permanency to develop additional in-service curricula to be implemented by the field. The training is anticipated to roll out in the spring of 2022.

FY 2017

The Department must develop resources, including funding for residential treatment centers, to develop their own step-down foster homes (from OIG FY 2017 Annual Report, Death and Serious Injury Investigation 6).

FY 2021 Department Update: In fiscal year 2021 the Department engaged foster care providers to increase capacity to serve kids stepping down from residential treatment settings. The need includes current kids awaiting discharge to foster family settings and meeting the new expectations of time limited stays in qualified residential treatment program (QRTP) settings. Currently there are 3 foster care providers developing proposals that would develop homes which would be for youth exiting residential care. Models for all three include: specific recruitment and development plans targeting homes for kids in residential treatment settings; clinical training for foster parents related to client needs; focus on early involvement for foster parents including matching families to clients; family active involvement during treatment stays; resources to support family during treatment stays; development of robust post discharge support including utilizing the clinical expertise of residential treatment teams; respite and focus on nontraditional support services; and development of a flexible rate structure to support the above items. The Department is currently developing a resource recruitment plan which will target additional foster care providers to put forth proposals that include targeting youth stepping down from residential treatment settings.

INVESTIGATIONS

This Annual Report covers the time period from July 1, 2020 to June 30, 2021 (FY 2021). The Investigations section has three parts. Part I includes summaries of child death and serious injury investigations reported to the Department Director. Part II contains aggregate data and case summaries of child deaths in families who were involved with the Department in the preceding 12 months. Part III contains general investigation summaries conducted in response to complaints filed by the state and local judiciary, foster parents, biological parents, and the general public.

Investigation summaries contain sections detailing the allegation, investigation, OIG recommendations and the Department response. In the "Recommendations" section of each case, OIG Recommendations are in bold and the Department's responses to the recommendations follow.

PART I: DEATH AND SERIOUS INJURY INVESTIGATIONS

DEATH AND SERIOUS INJURY INVESTIGATION 1

DEATH

A 6-year-old was found unresponsive in her bed by her mother and stepfather. The mother and stepfather admitted that they gave the medically complex 6-year-old the mother's prescription of olanzapine to make her sleep. The mother and stepfather were both charged with involuntary manslaughter and felony child endangerment. The Department indicated the mother and stepfather for death by abuse, death by neglect, medical neglect, substantial risk of physical injury/environment injurious to health and welfare by neglect, and environmental neglect. At the time of the child's death, there was an open intact family services case that opened two months earlier. Following the death, the surviving sibling came into care of the Department.

INVESTIGATION

The deceased child struggled with behavioral problems, insatiable appetite, and weight gain most of her life. When the child was almost 4 years old, the family reported that she had trouble breathing at night and had issues with sleeping, toilet training, and behavior. The child was referred to multiple specialists throughout her life, but the family was non-compliant with ensuring she was seen by specialists.

The family was first investigated by the Department when the child was almost 2 years old and a neighbor found her alone outside. The stepfather was indicated for inadequate supervision. When the child was 3 years old and her half-sibling was 6 months old, a second child protection investigation alleged unsanitary living conditions in the family home. A third investigation alleged that the then 3-year-old child was seen naked in the back yard alone. Both of those investigations were unfounded.

A fourth investigation was initiated a year later when hospital personnel contacted the Hotline to report that the then 4-year-old child was brought to the hospital by her mother and stepfather with wax all over her body and a second degree burn on her inner left arm that had blistered. The injury was determined to be accidental. During the investigation, the child's primary care physician told the investigator that she had concerns about the child's weight and behavior, but the family had not followed through on specialist referrals. The investigator instructed the family to take the child to the doctor and the investigator submitted a DCFS nursing referral for the family.

The assigned DCFS nurse reported to the investigator that the parents took the child to the doctor as instructed and the primary care physician again provided referrals for specialists. The DCFS nurse told the investigator

that the child was on a waiting list for some of the referrals but had appointments scheduled for endocrinology and neurology. The DCFS nurse recommended care coordination and intact family services for the family in order to address ineffective health maintenance because the family reported insufficient resources. During the child protection investigator's final visit to the family's home, the investigator encouraged the family to follow through on medical appointments. The investigation was unfounded and there was no record that intact family services were offered to the family. The child also was never taken to the medical appointments.

In the eight months prior to the child's death, the Department investigated the family three more times. The fifth investigation was initiated following a call to the Hotline alleging that the child had been going to kindergarten dirty and smelling like urine, and the family home was observed to be dirty and had a foul smell. In addition, the child's younger sibling, then 3 years old, was observed to be dirty and without clothing, and had been locked in a room as discipline. The Hotline call floor worker did not document in the Hotline narrative that the younger sibling was reportedly locked in a room. During the child protection investigation, the investigator documented that the mother did not appear to be in good health and the stepfather reported that he was overwhelmed trying to take care of everyone while also working. Neither the investigator nor police that were called to the home believed the conditions of the home constituted environmental neglect.

While the fifth investigation was pending, the Hotline received a call following the mother's psychiatric hospital admission. The reporter stated that the mother was mentally and physically deteriorating due to a lack of psychiatric treatment, as she had not been taking her medication as prescribed and was not able to care for herself or her children. The reporter provided contact information for relatives who were also concerned about the family. The call was taken as related information to the pending investigation and no additional allegations were added. Five days after she was discharged, the mother was admitted to the hospital again, and another call was made to the Hotline. The report was again taken as related information and no additional allegations were added. The Hotline narrative stated that the mother was hospitalized due to increased issues with depression and she had recently stopped bathing or caring for herself. Both of her children were observed to be dirty, unbathed, and odorous. At the conclusion of the fifth investigation, the investigator provided the stepfather and mother with contact information for Safe Families. The investigation was unfounded for environmental neglect. None of the collateral contacts identified by the Hotline reporters were contacted.

Eight days after the fifth investigation closed, a sixth investigation was initiated following a report that the child was going to school dirty, odorous, and without appropriate shoes. While the sixth investigation was pending, a seventh investigation was initiated after a call to the Hotline alleged concerns that the child had poor hygiene and may have had an untreated fungal infection. The reporter also stated concerns about the mother's mental health and ability to care for her children.

During the investigation, the child's primary care physician examined the child and told the investigator the child had no rash or fungal infection, but stated the child had several underlying issues including developmental issues with toilet training, neurological issues, endocrine issues, and possible psychiatric problems. The doctor stated that she has referred the child to specialists but there had been difficulties in following up with appointments. The doctor opined that this was not intentional medical neglect, but that the family needed help in the home and with transportation. Relying on the doctor's characterization of the neglect as unintentional, the child protection investigator unfounded the investigation and the family was referred for intact family services.

The intact family services case was opened two months prior to the 6-year-old child's death. At the transitional visit with the investigator and intact worker, the mother agreed to sign consents for the investigator and intact worker to contact her psychiatrist. There was no record that the investigator or the intact worker talked to the psychiatrist or received records, therefore staff remained unaware that the mother was inconsistent with managing her mental health. The intact family services worker made weekly phone contact and monthly in-

person contact with the family. The family was provided with information for counseling for the child, but the family never followed up.

RECOMMENDATIONS

1. As previously recommended in a prior Inspector General investigation, the Department should develop a form similar to the CFS 968-90, Questions for Mental Health Professionals to be utilized by child protection staff when interviewing mental health professionals regarding an alleged perpetrator.

The Department agrees. Child Protection will collaborate with the Clinical Division for revisions to the form to be used as an investigative tool in child protection.

2. The Department should update the CFS 968-90, *Questions for Mental Health Professionals* form for intact family services and provide guidance to intact staff on the use of the form.

The Department agrees. Direction will be provided to intact staff and the CFS 968-90 will be added to Procedures 302.388, *Intact Family Services*. The Policy Division is also making updates to the form. Additionally, this was an agenda item at the Statewide Intact Provider Meeting on November 16, 2021 that includes all Intact supervisors, Area Administrators and POS agencies.

3. SCR Administrators should review Hotline calls from the fifth child protection investigation and provide additional training to involved SCR staff.

The Department agrees. The Deputy SCR Administrator met with the involved call floor worker and supervisor and reviewed the call with the worker and supervisor and provided training related to the call.

4. The Department should develop a referral form, similar to the CANTS 65-A, *Referral Form* for Medical Evaluation of a Physical Injury to a Child, that is specific to allegations of medical neglect.

The Department agrees. The Department is currently working with the Medical Director to create a CANTS form to be utilized by child protection investigators in gathering information from medical professionals when determining if medical neglect is present. In addition, software changes have been put in place for DCFS nurses to be paralleled into Medical Neglect Investigations. Operations and the Clinical Division are also partnering to give clear direction to front-line staff regarding medical neglect allegations and referrals.

5. The Department should amend Procedures 300, Appendix B, *Allegation of Harm #79-Medical Neglect* to include the following required activity, "If a child has special health care needs, as defined in Procedures 302, Appendix O, *Referral for Nursing Consultation Services*, the Child Protection Specialist must complete a DCFS nurse referral."

The Department agrees. The recommendation will be incorporated into procedures. In addition, software changes have been put in place for DCFS nurses to be paralleled into Medical Neglect Investigations. Further, Operations and the Clinical Division are partnering to give clear direction to front-line staff regarding medical neglect allegations and referrals.

6. The Department should provide training and guidance to front line staff on the services and benefits offered through various Medicaid providers (i.e. transportation to medical appointments, pharmacy benefits, behavioral health services, complex case management services, etc.) that may be accessible to clients. The resource guide developed by OIG should be adapted for use by front line staff and made available on the D-Net.

The Department agrees. The Department is developing new Town Hall Meetings to continue to educate the field staff on transitioning from Medicaid to YouthCare. These Town Hall Meetings are expected to occur in early 2022. The resource guide was posted on the D-Net.

7. A redacted copy of this report should be shared with the Office of Learning and Professional Development to be used in training and utilized in Error Reduction Training.

The Department agrees. The Office of Learning and Professional Development is leading a multidisciplinary workgroup to review the existing Error Reduction Training content. The report will be shared with the workgroup. The OLPD plans to work with OIG to restart the Error Reduction Training in 2022.

8. A redacted copy of this report should be shared with child protection management for use as a case discussion tool with child protection staff.

The Department agrees. A redacted report will be added as an additional discussion tool for child protection staff.

9. A redacted copy of this report should be shared with the child's treating hospital.

The Department agrees. The Inspector General shared a redacted report with the President and CEO of the involved hospital.

10. The child protection investigator in the fifth investigation should be disciplined for the delay in contacting the reporter and failure to contact collaterals identified in the report.

The Department agrees. The discipline is in process.

11. The report should be shared with the Area Administrator.

The Department agrees. The report was shared with the Area Administrator.

DEATH AND SERIOUS INJURY INVESTIGATION 2

DEATH

Two unrelated children with medical complexities who received services through the Department's high-risk intact family services team died as a result of their medical conditions. A 2-year-old was found unresponsive by an in-home respiratory therapist. The child's specialized medical equipment needed for breathing was not plugged in or placed appropriately. The child was later pronounced deceased at the hospital and the cause of death was determined to be asphyxia due to disordered breathing related to Down syndrome. The Department indicated the 20-year-old mother and the 23-year-old father for death by neglect.

A medically complex 3-year-old was found unresponsive in the early morning by her 25-year-old mother. The mother's 25-year-old paramour alerted the mother after hearing the child's ventilator alarm. The child was later declared deceased at the hospital and the cause of death was determined to be complications of genetic anomalies. The mother was indicated for death by neglect after it was determined she shut off the child's ventilator alarm and slept in a different room despite previous instruction to sleep in the same room as the child. The child's 1-year-old sibling was subsequently placed with his father, who was not involved in the case.

INVESTIGATION

One year prior to the death of the 2-year-old, the Department opened an investigation for neglect against the parents. The child's medical providers reported that the child's medical complexities made the child susceptible to on-going complications and the allegations were unfounded. The child protection investigator referred the case to the State's Attorney's Office for consideration of court involvement. However, a petition was never filed, and the Assistant State's Attorney told OIG investigators that during this timeframe, the practice was only to file petitions if the Department took protective

custody of a child. The Assistant State's Attorney reported that the office practice changed, and currently petitions are filed in cases both with and without the Department taking protective custody.

The Department initiated services through high-risk intact family services to address issues with the child's weight gain, parents understanding and participation in medical appointments, and environmental issues in the home. Throughout the case, professionals reported that the parents did not understand the seriousness of the child's medical condition, the importance of attending medical appointments, and using medical equipment as required. Despite the on-going concerns, the high-risk intact family services supervisor told OIG investigators that the case was not referred to the State's Attorney's Office. The supervisor erroneously believed an indicated report was needed to file a petition for court intervention.

A DCFS Nurse made recommendations for the worker and family at the outset of the case and then had no further involvement. The family received services from the Division of Specialized Care for Children (DSCC) to assist with in-home services for the child. Over three months, the child was hospitalized four times. During the child's fourth hospitalization, which lasted approximately five months, intact family staff determined the parents made satisfactory progress despite being rated as unsatisfactory on following recommendations, using sign language consistently, and ensuring the child wore hearing aids while awake.

The Department closed the high-risk intact family services case after seven months and the child remained hospitalized because of difficulty securing in-home nursing services 16 hours per day, seven days per week. The high-risk intact family services supervisor told OIG investigators that the mother requested to terminate services after the intact worker resigned and the mother did not want to work with a new professional. The supervisor stated that services were voluntary and while there were concerns, the supervisor did not believe risk was immediate. The child was discharged a month later after in-home nursing services were secured. However, the assigned nurse quit after one shift and the child went without in-home nursing care for one month. DSCC assisted the family with locating nursing services for the full 16 hours per day, but a nursing shortage impacted securing the needed in-home services. The child only received nursing services for seven to nine hours, four days per week.

The family of the medically complex 3-year-old became involved with the Department eight months prior to the death when the Department initiated a child protection investigation involving failure to thrive. The child had been hospitalized seven times in the preceding four months related to medical complexities. The child depended on a tracheostomy tube, feeding tube, and ventilator. Medical providers expressed concerns about the child's weight loss and the mother did not follow the medication and treatment regimen. The mother also appeared to have difficulty comprehending the complexity of the child's care and required additional assessment. The mother relied on her paramour for most of the care for the child and the 1-year-old sibling.

The child protection investigator assigned the mother tasks including setting alarms on her phone for the child's feeding and medication schedule. The allegation against the mother was unfounded after the primary care provider was unable to rule out a medical cause for the child's failure to thrive. The child protection investigator referred the family for high-risk intact family services and recommended the mother participate in a mental health assessment to determine her ability to care for the medically complex child. A parenting capacity assessment was not considered. The family received services from multiple in-home providers and DSCC.

Approximately four months after case opening, the paramour and mother ended their relationship and the mother lived in two different relatives' homes before obtaining her own housing. While the child was approved for 123 hours per week of in-home nursing, one nurse covered 40 hours per week and there was no indication that additional nursing assistance was pursued. Throughout the case, the nurse reported concerns about the mother's ability to manage the child's medication and feeding regimen. The mother also had difficulty sterilizing the medical equipment as required. The nurse organized all medication for the mother to administer over the weekends but informed the intact worker that when the nurse returned to the home on Mondays, it

appeared that the mother did not give the child all the medication. The nurse also reported to the intact worker that she provided care to the sibling and completed household tasks because the mother slept or left the children in the nurse's care during shifts in the home. The intact worker arranged for a homemaker to assist the mother, but there were documented difficulties in contacting the mother.

Seven months after the intact case began, the Department initiated a second investigation after the child's ventilator was not plugged in and the child developed an open sore because the mother did not change bandages. The mother admitted to missing dosages of the medication, but the child's doctor observed no impact of the missed medications. The child protection investigator outlined tasks for the mother that included ensuring the child received all feedings, medications and treatment as prescribed. The child protection investigator's supervisor reported that a safety plan was not considered because there was no foreseeable end to the plan. The child protection investigator and intact services staff discussed the case and agreed that the mother knew the required care but had difficulty with follow-through and consistency. The investigation was subsequently unfounded as the doctor opined the child exhibited no physical decline.

While services continued through the high-risk intact family program, the in-home nurse resigned because of the difficulty in working with the mother and issues in the home. The high-risk intact family supervisor reported concerns about the mother's ability to care for the child, but, according to the supervisor, the case was not eligible for referral to the State's Attorney's office because there was no indicated finding against the mother, which she reported was the practice of the State's Attorney's Office at the time. Two days prior to the death, the child was hospitalized overnight for vomiting and diarrhea. Intact family services staff discussed the case that same day and documented that there had been no in-home nursing services since the nurse resigned.

Both children had medical complexities and lived with parents who struggled to provide the needed level of care despite linkage to multiple service providers. The Department recognizes the difficulty associated with such cases and issued revisions to Department procedures for medically complex children. Both cases were opened prior to the issuance of the revisions and the changes encompass several issues in these cases including investigating allegations of medical neglect, opening cases with medically complex children, and assessing a parent's ability to understand as well as provide the appropriate level of care. The revisions also provide guidance on referring cases to the State's Attorney's office and consultation with the Office of Legal Services for assistance and consideration of initiating dependency petitions. The new policy provides direction on utilizing DCFS Nurses and the Medical Director to assist staff in articulating the needs of medically complex children and the risks associated with improper or inadequate care.

RECOMMENDATIONS

1. This report should be shared with the DCFS Medical Director, the Chief Nurse, and the Deputy Director of Clinical Services for the continued monitoring of cases with medically complex children.

The Department agrees. This report was shared with the DCFS Medical Director, the Chief Nurse and the Deputy Director of Clinical for the continued monitoring of cases with medically complex children. The Medical Director and Chief Nurse maintain close contact with the Guardian's Office, Placement Administration and Skilled Care agencies through monthly reporting for ongoing reports and updates on medically complex children.

2. As previously recommended in a prior Inspector General investigation, a DCFS nurse should be assigned for the duration of intact family services cases involving medically complex children. Their duties should include attending home visits with the intact caseworker to meet with the family, attending medical appointments with the family and the intact service worker, communicating with medical providers, assisting with the medical and health related sections of the integrated assessment, and participating in Child and Family Team Meetings to help the family develop a plan to ensure that the

children receive their medical care. OIG reiterates this recommendation and, as noted in the previous Annual Report, acknowledges that the Department is working on its implementation.

The Department agrees. Within one week of case opening, the Intact worker shall convene a phone conference with the assigned DCFS Regional Nurse, if there is already a nurse assigned and the referral is still open or make the appropriate referral to have a DCFS Regional Nurse assigned.

A presentation was developed and shared at the state-wide Intact Provider Meetings in November 2020. A copy of the presentation was also distributed to all participants. In addition, all agencies on the relevant sub-committee of the Child Welfare Advisory Committee received a copy. This information was also shared and discussed at an all-staff Intact meeting in March 2021.

3. Policy Guide 2020.16, *Procedures 302.388, Intact Family Services,* noted that revisions to Procedure 302, Appendix O, *Referral for Nursing Consultation Services*, would be forthcoming. As such, this report should be shared with the committee tasked with revising Rules and Procedures 302, Appendix O.

The Department agrees. The report was shared and the information was incorporated in a draft of Procedures 302, Appendix O, *Referral for Nursing Consultation Services.* The Division is in the process of finalizing Procedures 302, Appendix O.

4. In response to a previous Inspector General recommendation, the Department committed to developing training in collaboration with the Administrative Office of Illinois Courts (AOIC). This report should be incorporated into the training and the training should be expanded to include caseworkers and supervisors.

The Department agrees. The Department is working with the AOIC to ensure alignment of the content that they are teaching their target audience of attorneys and judges. Trainings have been expanded to include both child protection and intact leadership at the regional and local field office levels. For the Department, these field-led trainings will occur during management and team meetings and presented to private sector intact leadership during regional provider meetings with the expectation that they pass the training down through their management to staff and supervisors.

Child protection and intact leadership is drafting staff memos to DCFS Child Protection and Intact field offices and private sector intact agencies informing them of the information and practice expectations. This information will also be shared and available on the D-Net.

A quick reference guide is also being created that will be used for intact training. The Quick Guide will cover the points and circumstance in intact cases when court intervention is needed. The field-led training for existing staff is excepted to be completed by the end of January 2022.

To ensure staff entering the field for Child Protection and Intact are trained with the same information, this same content will be included in Foundations training as teaching points and handouts ensuring all new hires and transfer staff are educated on the three types of protective orders.

5. This report should be shared with high-risk intact family services supervisor from both cases, the employee's current supervisor, the Regional Administrator, and the Deputy Director of Intact Services.

The Department agrees. The report was shared with the identified staff.

6. The high-risk intact family services supervisor should be counseled regarding her misbelief that referring cases to the State's Attorney's Office requires an indicated report.

The Department agrees. The case was reviewed with the supervisor and counseling was issued.

DEATH AND SERIOUS INJURY INVESTIGATION 3

SERIOUS INJURY A 6-month-old suffered bilateral skull fractures and a subdural hematoma. The child abuse specialist ruled the injuries occurred during two separate incidents and were caused by abusive head trauma. While the infant was in the care of both parents at the time of injuries, there was no evidence to identify a specific perpetrator thus the allegation of head injuries was indicated to an unknown perpetrator. Both parents were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect. The Department obtained custody and placed the infant with a relative.

INVESTIGATION The Department initiated the first child protection investigation with the family after the then 4-week-old sustained an ear injury and bruising to the back. The 29-year-old mother and 27-year-old father took the infant for medical evaluation twice over the course of a week but had no explanations for the injuries. The father opined the ear injury resulted from the way he held the infant cradled against his body. The infant was admitted to the hospital for evaluation at the instruction of the primary care provider.

During the child protection investigation, both parents denied issues with substance use, domestic violence or mental illness. The child protection investigator initiated a safety plan that required all visitation to be supervised in the hospital and that a medical professional needed to determine the injuries were not abusive to terminate the safety plan.

During an interview with law enforcement, the father reported that the infant's ear injury was from a spider bite, which contradicted his earlier explanation. The child protection investigator did not observe the interview or review the police report that was part of the attachments of the investigation. The child protection investigator explained they had not reviewed the report because the officer had been interviewed by the child protection investigator.

While the infant remained hospitalized the child protection investigator consulted with a child abuse specialist who determined the bruising as abusive specifically noting that ear injuries in infants were highly indicative of abuse. The child abuse specialist recommended the infant remain hospitalized for additional evaluation, including reviewing results of the skeletal survey, and that DCFS and the specialist be consulted prior to the infant's hospital discharge. Two days later the infant was discharged, and a safety plan remained in place for the parents to be supervised. There was no documentation that the child abuse specialist was consulted prior to discharge or results of the skeletal survey were reviewed. The mother later refused a second skeletal survey for the infant, which was recommended by the child abuse specialist. The infant's home was assessed to be appropriate and relatives provided supervision.

A detective and the child protection investigator returned to the family's home four days after discharge. During this visit, the detective found nothing that would have caused the infant's injuries and informed the parents there was no evidence they abused the infant. The criminal investigation was subsequently closed with no referral to the State's Attorney's Office. The child protection investigator also documented that the detective reported showing pictures of the infant's injury to a colleague, who was not assigned to the case. The colleague did not believe the injuries were abusive and believed the injuries could have been accidental. That same day, the child protection investigator ended the safety plan and determined the home as safe citing that the parents were appropriate, relatives had no concerns, the child abuse specialist did not identify a specific mechanism for

the bruising, there was no evidence suggesting physical abuse, and the bruising could have been accidental. The child protection investigator did not contact the child abuse specialist to discuss law enforcement's opinion that the injuries were accidental. OIG determined that the colleague the detective consulted had no specialized training in bruising to infants.

One month later, the investigation was closed as unfounded. The rationale included that while bruising to infants was suspicious, not all injuries were abusive, and this injury may have been accidental. Neither the child protection investigator nor the supervisor involved the Area Administrator despite the requirement to obtain approval in bruising investigations involving children under 6 months. In interviews with OIG investigators, the child protection investigator and supervisor were unable to explain or justify the reason for unfounding the investigation, and the supervisor was unable to explain why the child abuse specialist's findings were disregarded. The child protection investigator stated that the parents appeared credible and sought medical attention for the infant. The child protection investigator allowed positive opinions of the parents to outweigh the evidence that the infant's injuries were abusive, a phenomenon known as the rule of optimism. Such an outlook allowed for a failure to utilize critical thinking skills essential to performing investigative duties and disregarding the medical opinion of a trained child abuse specialist.

RECOMMENDATIONS

1. The Department should pursue discipline against the child protection investigator from the first investigation as deemed appropriate for the myriad and admitted failures in this case.

The Department agrees. The employee was issued a written reprimand.

2. The Department should pursue discipline against the child protection investigator's supervisor from the first investigation as deemed appropriate for the myriad and admitted failures in this case.

The Department agrees. The Department has initiated the disciplinary process.

3. This report should be shared with the supervisor and area administrator from this region for purposes of continued supervision.

The Department agrees and has shared the report with the supervisor and Area Administrators.

4. The Department should conduct a review of the child protection investigator and supervisor's cases involving allegation of physical abuse to children under age 6 to ensure appropriate outcomes.

The Department agrees. The Area Administrator conducted a review of the applicable cases.

5. If a Department contracted child abuse pediatrician is consulted with during an investigation of physical abuse, the child abuse pediatrician must be notified of the outcome prior to investigation closing.

The Department agrees. This was addressed at a Regional Supervisors meeting.

6. The DCFS Office of Learning and Professional Development should create an online/on demand training course on decision making and the rule of optimism using this case as an example.

The Department agrees. The Child Protection Division will collaborate with the Office of Learning and Professional Development on curriculum for this training and use this case as a case example.

7. There should be an automatic electronic notification process to notify the Area Administrator where there is physical abuse to a child under 3 and the Area Administrator must review the case prior to closure.

The Department agrees. The Department is in the process of procuring a new Comprehensive Child Welfare Information System (CCWIS). These functional requirements will be included as part of the Functional Design Requirements. In the meantime, the Area Administrators get a weekly report of the children under age 3 and are required, per procedure, to document their assessment at the time of the safety decision.

DEATH AND SERIOUS INJURY INVESTIGATION 4

DEATH

A 6-month-old infant was found unresponsive by her mother's paramour who provided care for the infant and 2½-year-old sibling while the mother worked. The paramour reported placing the infant in an adult bed with a bottle of formula propped in her mouth 15 minutes earlier. Emergency services transported the infant to the hospital where she was pronounced deceased. The Department initiated an investigation that was unfounded against the paramour for death by neglect but indicated for inadequate supervision. The Department subsequently obtained temporary custody of the sibling after abusive injuries were observed. The sibling was placed with maternal relatives.

INVESTIGATION

At the time of the infant's birth, the Department received a report that the infant and mother tested positive for substances initiating a child abuse and neglect investigation. The on-call child protection investigator met with the 18-year-old mother in the hospital, who denied substance use but agreed to participate in services through the Intact Family Recovery program, a program specializing in intensive services for infants with substance exposure. The primary child protection investigator visited the mother, infant, and then 2-year-old sibling at the home of the maternal grandmother after hospital discharge. The child protection investigator assessed the home as safe and the mother and grandmother agreed to a safety plan. The mother again agreed to participate in intact family services. However, over the next four months the child protection investigator did not document any investigative activities, including monitoring the safety plan, which required a visit to the home every five days. The children were seen once by another child protection investigator, who completed a well child check with both children while being cared for by the grandmother. During this time, the field office handling this investigation reported personnel vacancies and high caseloads. The primary child protection investigator had three different supervisors assigned during this investigation. Extensions were granted three times for this investigation because the child protection investigator failed to complete the referral for intact family services. It was reported to OIG investigators that extensions are no longer granted for incomplete tasks including referrals to intact family services.

Four months after the initial Hotline call, the child protection investigator referred the family for intact family services, rather than to the specialized intact family recovery program. The child protection investigator then completed the handoff to intact family services a month after making the referral and completed a safe CERAP, ending the safety plan. The child protection investigator's supervisor conducted final supervision on the investigation that was then closed as indicated against the mother for substance misuse by neglect to the then 5-month-old infant.

At the time of case opening, the mother lived with her paramour, whom she began dating approximately four to six months earlier. It was reported that the paramour had gang involvement that may place the children at risk. The intact worker conducted three visits with the family in the month prior to the infant's death. During

two of the visits, the intact worker noted injuries to the 2½-year-old sibling. The first injury reportedly occurred after the child fell down the stairs and sustained bruising. The mother had taken the sibling to the physician and provided the intact worker with documentation. A week later the intact worker returned to the home after the Department initiated an investigation for a 'burn like" injury on the forehead of a sibling. The mother explained the injury was self-inflicted after the child repeatedly struck his head against the wall during a time out. The child received medical attention and was given an ointment for treatment. While this child protection investigation was pending, the infant was found unresponsive. The Department later unfounded the allegations against the mother for burns to the sibling citing that she took the child for medical care and that she eventually intervened when she observed the child engaging in self harm.

RECOMMENDATIONS

1. The Department should review the referral process for Intact Family Services. As this case demonstrates, the timeliness of referrals is an issue and the referral process is not adequately monitored or enforced. The Department's review of the referral process should address streamlining the process by deleting duplicative or unnecessary steps, delineating a clear path of administrative review to ensure timely referrals, and assessing barriers to referrals.

The Department agrees. The referral process has been formalized in draft Procedures 302.388 (*Intact Family Services*).

2. The Intact Family Recovery coordinator should conduct a training for the region child protection investigation supervisors and area administrators to assure the field is educated about the program and the referral process. If the program regularly has openings, the coordinator should, through email or an announcement, inform supervisors of the openings.

The Department agrees. The former Intact Family Recovery (IFR) supervisor and team worked with prior region administration to share information and train staff on the Intact Family Recovery program. The current Intact Family Recovery supervisor will resume this practice with the new administrators and staff in the region.

DEATH AND SERIOUS INJURY INVESTIGATION 5

DEATH

The mother requested a neighbor call 911 after finding the 7-week-old infant not breathing. The 26-year-old mother and 37-year-old father appeared under the influence of substances. The infant was pronounced deceased at the hospital, and the medical evaluation found abrasions to the infant's scrotum and anus along with bruising on the back. The Department obtained custody of the infant's twin and 4-year-old sibling, who were placed in a traditional foster home. The cause of death was undetermined, and both parents were indicated for death by neglect. The parents were also indicated for substantial risk of injury and inadequate supervision to all three children.

INVESTIGATION

The family first became involved with the Department approximately one month prior to the infant's death when a neglect investigation was initiated for concerns about the parents' ability to care for their 19-day-old twins. The twins were born premature, and one twin experienced feeding and weight gain issues that required specialized formula and feedings every two hours. There were also concerns that the mother struggled with postpartum depression. The child protection investigator assessed the home as appropriate with no immediate safety issues noted, and the twins and a 4-year-old sibling as safe. The family had transportation issues and relied on public transit systems for medical appointments. The father disclosed a history of substance misuse as well as current telepsychiatry and

psychotropic medication for mental health issues. The child protection investigator's supervisor told OIG investigators there were concerns about the family, but the concerns did not rise to the level of immediate harm. According to the supervisor, the parents were not referred for drug testing because there was no concern of recent drug use and the nearest site was 45 minutes away, with no reliable transportation. Both parents agreed to participate in intact family services to assist in caring for three children under the age of 5 and address mental health issues. The infant gained weight during the investigation and the mother was screened for postpartum depression with no issues identified. The supervisor referred the family to the Department's high-risk intact family services program. However, the high-risk intact family program in that field office did not respond, and to ensure timely case assignment the family was assigned to a general intact family program. The supervisor responsible for assigning the intact case reported that the high-risk intact worker in that field office had the maximum number of cases assigned. According to the assigning supervisor, high-risk intact workers are capped at 10 cases to ensure manageable workloads. The child protection investigator and the private agency intact worker completed a transitional meeting with the family, who appeared receptive to services. Ten days later, the intact case was transferred to a different intact worker after the initial worker resigned from the agency. When the new worker returned to the home two weeks after the case opened, the parents refused services. Over the next several weeks, the private agency continued to experience staffing issues, and the intact worker assumed responsibility for all the agency's intact family cases. OIG's review determined that the private agency's staff turnover resulted in dangerously high caseloads.

As the child protection investigation remained pending, the intact supervisor contacted the child protection investigator to discuss status and possible case closure as the family no longer wanted services. The child protection investigator believed the case should remain open and offered to involve the State's Attorney's Office. The intact supervisor declined involving the court and instructed the intact worker to return to the family's home. The intact worker visited with the family on the day of the infant's death and noted the home appeared clean and neat. The intact worker observed both infants, who had no observable injuries, and the 4-year-old sibling had a red nose from being ill. The mother reported that both infants gained weight, thus the primary care provider no longer required weekly weight checks.

RECOMMENDATIONS

1. This report should be shared with the Deputy Director of Intact Family Services.

The Department agrees. The report was shared with the Deputy Director of Intact Family Services.

2. This report should be shared with the Agency Performance Team.

The Department agrees. The report was shared with the assigned agency performance team monitor and supervisor.

3. The Department should develop procedures to track the number of referrals for DCFS Intact Services that are reassigned to the private agencies due to the DCFS intact workers having full caseloads. This will allow for the Department to better measure the need for high-risk intact services in various regions, which will provide a more accurate determination of the number of DCFS intact workers the Department needs to maintain.

The Department agrees. The Department does not re-assign cases to private agencies due to DCFS worker's caseloads. Currently, the Department tracks the available capacity as well as the number of referrals by region, subregion, agency and caseworker.

4. This report should be shared with the Administer of the Substance Use and Recovery Program. The Department should continue to encourage the training and use of the Oral Fluid Drug Testing, especially in rural areas. The Area Administrator responsible for the Field Office in this report should facilitate sharing information if workers have not yet participated in the training.

The Department agrees. The report has been shared with the Administrator of the Substance Use and Recovery Program. Oral fluid drug testing training is available through the DCFS Virtual Training Center. The worker and supervisor in the case completed the oral swab training.

DEATH AND SERIOUS INJURY INVESTIGATION 6

DEATH

The 23-year-old father found the 7-month-old unresponsive after putting the infant down for a nap on a twin-size mattress nine hours earlier. The father was caring for the infant while the mother was at work. First responders performed CPR, but the infant could not be revived and was pronounced deceased at the scene. Law enforcement found significant environmental issues in the home as well as a weighted blanket and drug paraphernalia in the bed where the infant died. The cause of death was asphyxia due to airway obstruction by bedding materials. The father was indicated for death by neglect. The mother and father were both indicated for environmental neglect and substantial risk of physical harm/ environment injurious to health and welfare by neglect because of the conditions of the home. The Department obtained custody of the 7-year-old and 9-year-old siblings who were placed with relatives.

INVESTIGATION

The Department first became involved with the mother in 2012 regarding two older siblings to the deceased. The Department unfounded two investigations related to the mother's substance use. In 2015, the Department initiated a third investigation involving the mother's supervision of the two siblings both under the age of 5. During the investigation, issues of domestic violence and substance use were identified, and the mother was indicated for neglect.

The Department provided intact family services to address domestic violence, substance use, and financial instability for approximately three months. During that time, the mother's parole was revoked and she was incarcerated. The siblings were in the care of their fathers and their maternal grandmother and the intact family case was closed.

Two months later, a fourth investigation involving the mother and her children was unfounded for neglect related to environmental issues in the home. The fifth investigation initiated in October 2019 involved continued environmental concerns in addition to reports that the 31-year-old mother and her 22-year-old paramour had substance use issues including selling and trading drugs. The assigned child protection investigator visited the home, found no environmental issues, and noted the 7-year-old sibling appeared shy and could not be interviewed outside of the parents' presence. The child protection investigator did not make any further attempts to interview the 7-year-old, who had witnessed the parents' substance use and possible drug commerce. The deceased, who was the only child of the mother and paramour, was born one month earlier and appeared safe.

The parents, who the child protection investigator interviewed together, reported histories of substance use and mental health issues but denied any current use or issues. The child protection investigator did not obtain detailed information about prior substance treatment or information about medications prescribed despite photographing a medication bottle while in the home. The child protection investigator did not obtain detailed information from law enforcement about the parents or review the family's prior Department involvement.

The child protection investigator interviewed the 9-year-old at school and subsequently determined that an incident did not occur. The child protection investigator did not ask the child about family support or follow up with information provided by the reporter about the parents' drug use. The child protection investigator determined the investigation was unfounded for neglect, at the initial stage, against both parents to all three children.

The temporarily assigned supervisor, who had no prior experience or training for providing supervision, approved closure of the investigation at the initial stage and did not send it for review by the Area Administrator as required. Closing the investigation at the initial stage allowed for critical information from key collaterals to be missed. The child protection investigator accepted self-report as the source of evidence leading to the determination that the children were safe in the home.

RECOMMENDATIONS

1. This report should be shared with the Regional Administrator from this region, the current Area Administrator for this team, the Public Service Administrator, the temporarily assigned Public Service Administrator, and the Child Protection Investigator from the fifth investigation as a teaching tool.

The Department agrees. The Department shared a redacted report with the recommended staff.

2. In the absence of the Public Service Administrator, only the Child Protection Advanced Specialist or Area Administrator should be allowed to approve a Child Endangerment Risk Assessment Protocol and/or provide a Final Supervisory Decision.

The Department agrees. The Department will require that when a child protection team has a new temporarily assigned supervisor who is not a child protection advanced specialist, the child protection team must have a discussion with the Area Administrator before the CERAP can be approved.

3. The Department should incorporate the Subsequent Oral Report Memo into Procedures 300, *Reports of Child Abuse and Neglect*, as stated in the Memo and in the response to the FY20 OIG Annual Report.

The Department agrees. The Department will incorporate into Procedures 300, *Reports of Child Abuse and Neglect*, clear direction on the use of a family's prior history to inform and direct investigative activities. The Department is actively working with the Office of Legal Services, Child Protection and the Office of Child and Family Policy on incorporating these changes into Procedure 300, with expected completion by the end of 2021.

4. The Office of Learning and Professional Development should review Foundations Training and incorporate training material on the use of a family's prior history to assess risk.

The Department agrees. The Office of Learning and Professional Development will work with Child Protection and Intact Family Services to review the existing Foundations content and make appropriate changes.

5. OIG Error Reduction Team will develop a "Booster Training" for all current Child Protection Investigators and Supervisors to address the use of a family's prior history to assess risk.

The Department agrees. The OIG is working in collaboration with the DCFS Office of Training and Development to develop the training.

Death and Serious Injury Investigation 7

DEATH

A 1-month-old was found unresponsive by the 23-year-old mother after co-sleeping in an adult bed. Upon finding the infant that morning, the mother called 911. The 31-year-old father fled the home because of an outstanding warrant from an incident of domestic violence with the mother two weeks earlier. The Department obtained custody of the 3-year-old sibling and placed the child with fictive kin. The infant's cause of death was determined to be viral pneumonia. The Department initially indicated the mother for death by neglect but later unfounded the allegation. Both parents were indicated for substantial risk of harm to the sibling and the father was indicated for substantial risk of sexual abuse for access by a sex offender.

INVESTIGATION

Between 2016 and 2019, the Department initiated four child protection investigations and provided case management services to the family. The mother and father had a pattern of domestic violence and failure to adhere to orders of protection throughout their Department involvement. The first child protection investigation was initiated after the Department received reports of risk of harm to a 7-week-old infant. The mother reported that the father threw her down the stairs, but the infant was not home during the altercation. The mother obtained an emergency order of protection but did not attend the plenary hearing reporting she was no longer frightened, and the couple had a complicated relationship. The mother agreed to move out of their shared home and to abstain from contact with the father. The father is a registered sex offender and was convicted of criminal sexual assault nine years earlier. The father denied domestic violence and misrepresented his completion of sex offender treatment. The family was referred for intact services. Both the mother and father were indicated for substantial risk of harm to the infant. The father was also indicated for risk of harm related to his status as a sex offender.

Intact family services began in September 2016 and staff knew of the father's registered sex offender status and the prior order of protection obtained by the mother. According to the prior sex offender assessment obtained by the caseworker, the father did not complete treatment, could not be around girls under 18, and was at moderate risk of re-offending. One month after the intact family case was opened, the mother and father moved in together after the father pled guilty to domestic battery. A second investigation was initiated during the intact case for inadequate supervision which was subsequently unfounded and expunged.

The parents participated in services to address substance use, parenting, and domestic violence. During a dispositional hearing, the court granted guardianship and custody of the infant to the Department with placement discretion. The infant remained in the care of the parents, but the case was transferred to a different agency. Three months later, the mother reported ending her relationship with the father because of sexual and emotional abuse. The mother was referred for additional supportive services and obtained an emergency order of protection against the father. One month later, a new order was entered for no contact between the parents with supervised visits between the father and infant. The mother completed recommended services to address domestic violence and parenting resulting in the court returning custody of the infant to the mother. The father did not make progress or complete services and violated the order of protection. A supervision plan was entered that required the paternal grandparents to supervise visitation between the father and infant. The court subsequently returned guardianship to the mother and closed the case in February 2018.

Less than two weeks after case closure, the Department initiated a third child protection investigation involving possible substance use issues with the mother while caring for the then 2-year-old child. The mother initially agreed to complete drug testing, but moved out of state to live with relatives prior to completing the urine test. The child protection investigator coordinated with a child welfare investigator from the other state, who assessed the mother and found no concerns. The investigation was subsequently closed as unfounded for neglect allegations against the mother. In August 2019, the Department initiated the fourth child protection investigation with the family for domestic violence concerns. Law enforcement responded to the home after the

father, who had a firearm, threatened violence. The child protection investigator, who completed the third investigation, observed the 3-year-old child and the couple's second child, a 3-week-old infant. Both children were cared for well, with no signs of abuse or neglect. The mother reported the father attempted to strangle her in their backyard while the children were inside. The child protection investigator completed the home safety checklist with the mother, which included a review of safe sleep practices, and photographed a bassinet in the home. The child protection investigation was closed, and the mother was unfounded for neglect allegations because she ended the relationship with the father, changed the locks in the home, and obtained an emergency order of protection. The father was indicated for risk of harm for the domestic violence and his continued status of a sex offender who had not completed treatment. Despite a history of violence and failure to adhere to orders of protection, the child protection investigator did not refer the family for services or ensure the mother attended the plenary hearing for the order of protection. According to the county clerk's office, the mother did not attend the plenary hearing and the protection order was dismissed 13 days after the investigation was closed.

Both the child protection investigator and supervisor told OIG investigators that the required investigative activities were completed in two weeks and there was no need to keep the investigation open. During the OIG interview, the supervisor reported an informal conversation with the Assistant State's Attorney after approving closure about the possibility of future court involvement with the family but did not document the conversation in SACWIS. The supervisor reported families with risk factors are now referred to the State's Attorney's Office as required in a memo sent by the Department several months after this investigation. The cited memo instructed staff to forward information on families with multiple reports to the State's Attorney's Office for determination of court ordered intact family services. A second memo provided instructions and criteria for involving area administrators when family had a history of multiple reports and documenting decisions about referring families to the State's Attorney's Office.

RECOMMENDATIONS

1. This report should be shared with the supervisor and child protection investigator from the fourth child protection investigation for training purposes regarding the importance of considering a family's history with DCFS, especially when there are chronic and underlying issues that put the children's well-being and safety at risk.

The Department agrees. A redacted report was shared with the supervisor. The child protection investigator no longer works in the child protection division.

2. The Department must ensure that investigative teams have the resources to adequately execute the requirements outlined in the February 2020 Subsequent Oral Reports memo.

The Department agrees. Child Protection and the Office of Legal Services are currently incorporating the Subsequent Oral Report Memo into Policy and Procedure.

3. As previously recommended by the Inspector General, the Department should appoint a domestic violence coordinator in each region to liaison with domestic violence providers to enhance information sharing.

The Department agrees. There is a domestic violence specialist assigned in each region of the state. Additionally, there is a statewide domestic violence administrator who supervises the four regional specialists.

4. This report should be shared with the DCFS domestic violence coordinator.

The Department agrees. The report was shared with the DCFS domestic violence coordinator and the Statewide Domestic Violence Administrator.

DEATH AND SERIOUS INJURY INVESTIGATION 8

DEATH

The 16-year-old mother found the 7-week-old infant face down and unresponsive in bed after placing the infant in the bed with her four hours earlier. The infant was later pronounced deceased at the hospital. The infant's cause of death was determined as asphyxiation due to co-sleeping prone with probable overlay. The infant also had evidence of a rhinovirus at the time of death. The Department unfounded an investigation against the mother involving the infant's death. A companion investigation was opened at the time of the infant's death involving the maternal aunt with whom the mother and infant lived at the time of death. The maternal aunt had a history of domestic violence with her paramour that placed her four children at risk. The paramour lived in the home despite an active Order of Protection obtained by the maternal aunt. The maternal aunt's four children were taken into custody and placed in care and the maternal aunt was indicated for neglect to her children.

INVESTIGATION

The infant's death was the first involvement the Department had with the 16-year-old mother as a parent. The maternal aunt, whom the mother lived with at the time of the infant's death, had history with the Department involving allegations of neglect and domestic violence. The Department unfounded the first investigation against the maternal aunt in 2018 after reports of environmental neglect. The maternal aunt remediated the issues and the child protection investigator assessed the home to meet minimum standards for the four children ages 8, 6, 2 and 1. Two months later, the Department initiated a second investigation after the 6-year-old disclosed abuse by the aunt's paramour while the paramour was intoxicated. The maternal aunt and her paramour, who was the father of the two youngest children, had a history of domestic violence. While the 6-year-old confirmed the reports of violence in the home that resulted in police involvement, the 8-year-old denied witnessing violence or knowledge of police coming to the home. The paramour confirmed consuming alcohol but denied any abuse or violence. The maternal aunt also denied issues with domestic violence or police response to the home. The child protection investigator contacted local law enforcement who reported responding to the home for domestic violence less than three months earlier and completing a police report. However, the child protection investigator did not request or obtain additional information about the police report. The child protection investigator reviewed the paramour's criminal history, which included a significant amount of police involvement, with incidents of violence towards others. The Department received related information one month into the investigation that alleged a lack of supervision of the 1-year-old and 2-year-old. No new allegations were added to the investigation and the child protection investigator made a single attempt to contact the reporter of the related information prior to closing the investigation two weeks later. At a final visit to the home, the child protection investigator did not discuss the reported lack of supervision issues and assessed all four children as safe. The child protection investigator assessed the home and children as safe and closed the investigation as unfounded for neglect allegations as the children had not been in proximity to the domestic violence. The child protection investigator provided the maternal aunt with information on domestic violence community resources.

Less than a month after the second child protection investigation was closed, the Department initiated a third investigation after the 1-year-old and 2-year-old were found in the neighbor's yard unsupervised. The paramour cared for the children while the mother worked and reported he did not know the children left the home. The on-call child protection investigator interviewed the 6-year-old and 8-year-old siblings, who reported the paramour drank alcohol while caring for the children. One week later, the investigation was transferred to a second child protection investigator who re-interviewed the paramour who acknowledged a history of domestic violence but denied any instances in his current relationship with the maternal aunt. The maternal aunt and paramour agreed to participate in intact family services. The Department received related information that included a second occurrence of lack of supervision and environmental concerns that the child protection investigator discussed during a visit three weeks later. The maternal aunt and paramour reported difficulties with childcare which would be exacerbated because the paramour had to serve 30 days in jail. The child protection investigator did not ascertain the reason for the jail time. The investigation was closed as indicated

against the paramour for inadequate supervision of the two youngest children. In both the second and third investigations, the Department failed to recognize and address additional reports of neglect made in related information calls.

Prior to the transitional handoff between the child protection investigator and the High-Risk Intact Family staff, the Department initiated a fourth investigation after the paramour was arrested for domestic battery to the maternal aunt. It was reported the paramour was intoxicated at the time of the abuse. All four children were present during the incident and the oldest child attempted to intervene. The maternal aunt obtained an Order of Protection that included the children. A judge subsequently granted a plenary Order of Protection that was valid for two years, until 2021. In an interview with the child protection investigator, the paramour disclosed gang involvement and a history of violence when intoxicated. During a visit to the home, the child protection investigator found the children home alone and initiated a safety plan with the maternal aunt as the sole person responsible for ensuring the paramour did not return to the home. There was no assessment of the maternal aunt's ability to adhere to the safety plan considering their history of domestic violence. The child protection investigator did not discuss the maternal aunt leaving the children home alone or consider making a subsequent oral report. The investigation was closed as indicated for neglect allegations against the maternal aunt and paramour to all four children.

The intact family case opened in 2019 was assigned to a private agency intact worker and supervisor with minimal child welfare experience. Two months after case opening, a court order was entered that prohibited the paramour from being in the family residence and all contact with the children had to be supervised by the agency, thus terminating the prior safety plan. While the intact worker made routine visits to the home, there was no documentation of child interviews during visits. The intact case worker cited continuing to learn job requirements during an OIG interview as the reason for failing to interview the children during each visit. While visiting the 9-year-old at school, the child reported to the intact worker that the paramour had touched the sibling inappropriately. During an interview with OIG, the intact worker reported not asking additional questions about the situation because of a lack of training. The intact worker reported making a Hotline call but did not speak with a call taker and left a message for a return call. Records obtained by OIG confirmed the intact worker's call to the Hotline but revealed the intact worker did not answer the return call. The intact worker failed to follow-up with the message from the State Central Register and an investigation was not initiated. During an interview with OIG investigators, the intact worker provided information about the events that were not documented in the case record. The intact worker stated the report of possible sexual abuse was taken as information only because the perpetrator no longer lived in the home. The maternal aunt explained that the paramour touched the child over the swimsuit area, and it was not sexual. The intact worker's supervisor reported ongoing issues with the intact worker completing documentation as required. The child's outcry was not addressed until after the infant's death in a subsequent report where the paramour was indicated for sexual abuse. In an interview with OIG, the intact supervisor was unable to recall details of the child's outcry and the action taken. The intact supervisor documented in the record that the child's outcry was not reported because the child protection investigator from the fourth investigation already knew of the outcry. However, in an interview with OIG, the child protection investigator from the fourth investigation denied knowing of possible sexual abuse by the paramour. Throughout the intact family case, the paramour did not participate in services and was later arrested after stealing the maternal aunt's car. It was reported that the paramour was intoxicated and charged with several driving infractions including the theft. During subsequent visits, the intact worker did not discuss the events of the paramour's arrest with the maternal aunt or the paramour.

Four months after the intact case was opened, the pregnant 16-year-old mother moved into the maternal aunt's home. The intact supervisor instructed the intact worker to add the mother to the family case. The mother was never added, but the infant became a case member after the mother gave birth. The intact worker assisted the mother in obtaining public assistance and provided the mother with a pack and play. The intact worker told

OIG investigators that the pack and play was set up during a visit to the home and the intact worker provided the mother with education about the importance of safe sleep.

RECOMMENDATIONS

1. This report should be shared with the supervisor and private agency that handled the intact family services case. The agency should take appropriate disciplinary action, in accordance with the agency's personnel practice, for the supervisor's failure to ensure that the sexual abuse outcry was reported to the Hotline and taken as investigation.

The Department agrees. The report was shared with the supervisor and private agency.

2. This report should be shared with the State Central Register for learning purposes to address when calls on pending investigations should be taken as a subsequent oral report instead of related information.

The Department agrees. SCR administrators will share a redacted report with all supervisors in their Supervisor/leadership meeting. The Deputy Administrator reviewed Procedures 300.20, *Reporting and Documenting Child Abuse and Neglect to the Department*, with staff and staff were reminded when to take an initial oral report, subsequent oral report and related information. A redacted copy of the report will be discussed in each team meeting in the month of December 2021 with all call-floor workers and the SCR Administrator will issue a reminder memo to staff.

3. This report should be shared with the child protection investigator of the third and fourth investigations and their supervisor as a training tool.

The Department agrees. The report was shared with identified staff.

5. The Department's Office of Learning and Professional Development should reestablish and implement a specialty training for high risk intact family services caseworkers and supervisors.

The Department agrees. All DCFS or private sector intact family service teams may receive High Risk Intact cases, therefore all Intact staff and supervisors are receiving training in Foundations to address supporting families with high risk factors. The current curricula will be reviewed by intact leadership to determine if additional training content is needed specific to this population and make recommendations by January 15, 2022 for revisions that will be made by the end of June 2022.

DEATH AND SERIOUS INJURY INVESTIGATION 9

SERIOUS INJURY

The 24-year-old mother discovered her 2-year-old, the mother's fourth child, unresponsive with seizure-like activity in his carseat when she arrived at the maternal grandmother's house. The child was transported to the hospital where it was determined that the seriousness of the child's injuries required transfer to a second hospital for surgery to relieve brain swelling. The child had a skull fracture, subdural hematomas, retinal hemorrhaging and a possible ligament tear of the neck that were determined abusive. In the week prior to the serious injury, the mother had taken the child to the doctor multiple times with facial bruising, back pain, fevers, and an ear infection. The mother was indicated for neglect to her five children, who were then placed with relatives under a safety plan. The mother's 23-year-old paramour, and father of her fifth child, was indicated for the injuries as well as risk of harm to the siblings. The paramour was criminally charged for the injuries but acquitted of aggravated battery to a child at trial.

INVESTIGATION In the four years preceding the serious injuries to the 2-year-old, the mother and three different paramours were involved in five child abuse and neglect investigations, as well as intact and placement services. In July 2015, the Department initiated an investigation for abuse and neglect involving the mother's first paramour and her 5-year-old and 1-year-old children. The mother agreed to a safety plan with the maternal grandmother and to abstain from contact with the paramour. The child protection investigator observed the mother's home to have multiple environmental hazards, and the mother was subsequently indicated for environmental neglect. Allegations against the paramour were unfounded. In January 2017, the Department opened a second child protection investigation involving the mother's second paramour, who was the father of her third child. The paramour left his 9-month-old child and a 2-year-old sibling alone in a bathtub. The mother agreed to a safety plan for her children with the maternal grandmother, no unsupervised contact, and participation in intact family services. The mother and paramour reported smoking marijuana, and the mother acknowledged being pregnant with her fourth child. The mother and paramour were indicated for neglect and the Department opened an intact family services case. The mother participated in services for two months and reported the paramour no longer lived in the home and moved to a different city. The intact family worker informed the mother that contact between the paramour and her children placed them at risk and may result in the removal of the children from her care. After a substance use assessment, the mother did not meet the criteria for services, but was recommended to participate in mental health counseling.

During the intact family case, the Department opened a third investigation after the mother's third child, 11 months old at the time, sustained an arm fracture. The mother initially reported she fell down the stairs while carrying the infant. Further investigation revealed the infant sustained the injury during a car accident with the mother. The child protection investigator initiated a safety plan for the infant and 3-year-old sibling with the maternal relatives. The mother's oldest child had been living with the relatives prior to the investigation. Police documents obtained by the child protection investigator revealed that the mother reunited with her second paramour, and he was in the car at the time of the incident. Police found marijuana in the car which was in reach of the 3-year-old sibling in the back seat. When confronted about the facts of the police report, the mother reported failing to disclose her relationship with the paramour because she was instructed not to allow the paramour around her children. The Department obtained temporary custody of all three children, who were placed with maternal relatives. The Department indicated the mother for bone fractures to the infant and risk of harm for her two older children. The Department indicated the paramour for risk of harm to all three children. The intact family case was transferred to placement services in March 2017.

During the first three months of the placement case, the paramour did not participate in services and was detained in county jail for outstanding warrants. The mother continued to test positive for marijuana during her pregnancy and was informed that continued marijuana use jeopardized the return of her children. When the mother gave birth to her fourth child, the Department initiated and subsequently indicated a fourth investigation involving the mother. The mother's open placement case and prior involvement placed the infant at risk and the Department obtained temporary custody. The infant was placed with the siblings in the relative foster home. Over the next five months, the mother made progress in services, including counseling, parenting, and negative drug tests. Ten months after opening the placement case, the court returned all four children to the care of the mother and initiated after care services. During the six months of after care services, it was reported that the mother demonstrated skills learned in both parenting and counseling. The court returned guardianship to the mother, and her case was closed in July 2018.

In December 2018, the Department opened a fifth investigation involving the mother's supervision of her oldest child. The 8-year-old sustained injuries in a car accident with a different caregiver. While allegations for lack of supervision were unfounded, additional allegations were added after social media videos of the mother and her second paramour were reported to include marijuana use, weapons, and abuse. The assigned child protection

investigator accessed social media to view the videos and summarized the content in SACWIS. However, OIG review of the SACWIS documentation of the videos did not include pertinent details including the number of videos accessed, or specificity of the abusive incident. The mother and paramour denied the abuse and provided an alternate explanation. While the child protection investigator consulted law enforcement about the paramour's firearm, the child protection investigator failed to determine the type of weapon in the video. The paramour denied it was a firearm, but rather identified it as a BB gun that was no longer in the home. The videos were deleted from social media prior to being uploaded as part of the child protection investigation and were not available for use as evidence in the investigation. The child protection investigator documented that none of the children exhibited unease around the paramour, and the oldest child denied witnessing any abuse by the paramour to the mother or siblings. The mother and paramour tested positive for marijuana during the investigation, but the child protection investigator did not address the marijuana use or refer for services despite reviewing prior Department involvement. In the month leading up to the closure of the investigation, the child protection investigator conducted a visit to "complete a final CERAP" and told the mother the allegations would be unfounded despite instructions from the supervisor to complete additional investigative duties. The mother reported the paramour was no longer in the home and agreed to a referral for community services. The neglect allegations against the mother and father were unfounded. The investigation closed four months prior to the serious injury incident.

OIG review found that the child protection investigator's rationale did not match the allegations, and further cited the mother's completion of services as rationale to unfound neglect allegations against the paramour despite evidence that the paramour never participated in services. In an interview with OIG, the child protection investigator was unable to explain the determination of no risk in the home or the lack of referral for intact services. The child protection investigator had no concerns about the paramour's presence in the home despite knowledge of past involvement. The supervisor documented in SACWIS that the family declined intact services and told OIG that while there were concerns, there was not enough evidence to warrant intervention. In interviews with OIG, both the child protection investigator and the supervisor reported that the field office assigned to this investigation experienced high personnel turnover and high caseloads which impacted their ability to address complex family dynamics. The child protection investigator also reported providing supervisory coverage that impacted job performance and completion of duties.

RECOMMENDATIONS

1. Child protection investigations initiated within six months after the closure of the family's placement or intact family services case should require heightened review and consultation from the child protection Area Administrator.

The Department agrees. Child Protection and the Office of Legal Services are currently incorporating the subsequent oral report memo into Policy and Procedure.

2. When child protection investigators or caseworkers discover a video posted on social media that depicts the family engaging in behavior that is dangerous to the welfare or safety of minors within the household, the investigator or caseworker should immediately make a copy of that video before the video can be removed from social media. The Comprehensive Child Welfare Information System (CCWIS) committee should ensure that the Department's new data system is able to accommodate social media files.

The Department agrees. As the Department continues to progress towards developing CCWIS, the Department will ensure the new system is able to store multimedia files, including video, as part of the intake, investigation, case, expenditure, or persons and will investigate the feasibility of recording media from various social media platforms.

3. The Department should examine staffing levels, turnover and other related issues at the involved field office to determine what staff, resources and reforms are needed in this location to better serve children and families.

The Department agrees. The Department has put in place new monitoring tools to assist with identifying specific sites that are struggling with child protection staffing levels, and to target additional supports to those sites as appropriate.

4. The child protection investigator from the fifth investigation should receive training on Procedures 300 Appendix B, *The Allegation System*, on ensuring that the rationale for allegation findings is appropriate and relevant to the allegations. A copy of this report should be shared with the child protection investigator for training purposes.

The Department agrees. The report was shared with the child protection investigator for training purposes.

5. A copy of this report should be shared with the Area Administrator of the involved field office.

The Department agrees. The report was shared with the Area Administrator.

DEATH AND SERIOUS INJURY INVESTIGATION 10

DEATH

Emergency medical services responded to a report of an unresponsive 4-year-old in the home of the 20-year-old mother and 27-year-old paramour. Emergency medical services performed resuscitation efforts for 40 minutes and pronounced the child deceased at the scene. Medical evaluation of the 4-year-old revealed significant trauma including facial injuries, lacerations to multiple internal organs, and five broken ribs. The cause of death was determined to be multiple fractures and visceral injuries due to blunt force trauma of torso and head. The mother's paramour was charged with first degree murder. The 1-year-old sibling was taken into custody and subsequently placed in foster care. The mother and her paramour were indicated for death by abuse to the 4-year-old and additional neglect allegations to the 1-year-old sibling based on the conditions of the home and the death of the sibling.

INVESTIGATION

The child's mother was previously involved with the Department as a child and was later adopted by the maternal grandmother. In 2018, the Department became involved with the 18-year-old mother as a parent after the grandmother requested assistance three times over the course of four months with obtaining guardianship of the deceased, who was then 2 years old. The grandmother reported the mother and child lived with her and the mother was not ready to parent. The 2-year-old had special needs that required services. The reports were taken as information only and the grandmother was provided with information on community services to secure guardianship. Less than a year later, the Department received a fourth call expressing concern about the mother's care of the child. However, the call was disconnected before required information was obtained. In March 2019, the mother gave birth to her second child and the Department received a report that the mother tested positive for substances, while the infant's test results were pending. The call taker determined no investigation was warranted and the Department took no further action on the information.

In the year preceding the death of the 4-year-old, the Department initiated an investigation for environmental neglect. The on-call child protection investigator went to the home that same day and the mother reported that the deceased and 8-month-old sibling were not home. The mother did not allow the child protection investigator

in the home because the grandmother, who owned the home, was not present. Two days later the investigation was assigned to the primary child protection investigator who attempted to see the family at their residence. The family was not home, and the child protection investigator made two additional attempts to see the family over the next three days. On the third attempt, the child protection investigator left a letter for the family and ceased in person attempts at the instruction of the supervisor. In an interview with OIG, the supervisor stated that the field office handling this investigation had high caseloads and staff vacancies. The child protection investigator and supervisor reported to OIG investigators that because the allegation was environmental neglect and there were no identified risk factors, the decision to cease in person attempts was appropriate. The Area Administrator reported to OIG staff that generally child protection investigators attempt visits to see children at the onset of an investigation five days in a row. The Area Administrator also reported that a child protection investigator may request assistance from local police or from emergency service workers to see children in the evenings or on weekends. This region had two emergency workers and one supervisor that covered seven counties. Additionally, staff reported that law enforcement checks on children did not always happen in a timely manner. Neither option was exercised in this investigation. Approximately two months later, the child protection investigator visited the family for the only time and interviewed the mother and grandmother, and observed both children. The child protection investigator assessed both children as safe, noting that the deceased was nonverbal, which the mother stated was addressed through Head Start services. During an OIG interview, the child protection investigator reported contacting the school but was unable to obtain information over the phone because of the school's policy. The child protection investigator did not document the contact in SACWIS and did not attempt to obtain school information in person. The mother and grandmother denied environmental issues in the home. The mother refused to provide information about the fathers of her two children, citing they were not involved with the children. The child protection investigator completed the home safety checklist and all required screenings. The mother denied domestic violence, current orders of protection, or having a paramour. In an OIG interview, the child protection investigator reported finding no evidence of a man living in the home. While the child protection investigator documented reviewing DCFS records, during an interview with OIG, the child protection investigator reported no knowledge of the information only calls involving the family. The child protection investigator reported only conducting a person search in SACWIS if members of the investigation were unknown. The supervisor told OIG investigators that child protection investigators were not required to complete a person search and opined that the person search was "time consuming." The child protection investigator and supervisor reported that the neglect allegation was unfounded because there was no evidence to support the allegation and the home appeared clean. The child protection investigator reported that the mother did not request or identify any needed services thus the investigation was closed with no services needed.

RECOMMENDATIONS

1. This report should be shared with the child protection investigator and supervisor from the first investigation.

The Department agrees. The Regional Administrator and Area Administrator met with and discussed the redacted report with the child protection investigator and supervisor.

2. The Department should review the practice of waiving initial contact for children under 6 in this region.

A meeting was held on June 10, 2021 to discuss the redacted OIG report with the site and included the regional administrator, the area administrator and supervisor reviewing Procedures 300.70 (f), *Supervisory Responsibility for Reports Involving Children 6 Years of Age and Younger* and Procedures 300.70 (i), W*aivers*. In addition, the Deputy of Child Protection will also include a review of these procedures during the regional supervisory meetings.

3. The Department should ensure an adequate number of emergency services workers are available for after-hours and on weekends to ensure that children are being seen in a timely manner.

The Department agrees. Area Administrators met with child protection supervisors to discuss emergency services and discussed the process of calling in extra staff and managing the workload for emergency services child protection specialists and supervisors.

4. The Area Administrator should meet with the school as well as any other schools identified by the field to ensure that there are systems and processes in place for reliable sharing of information.

The Department agrees. The area administrator and regional administrator met with the school social worker and principal to discuss this concern and put processes in place to facilitate the sharing of information moving forward.

DEATH AND SERIOUS INJURY INVESTIGATION 11

DEATH

A 1-month-old was found with blood coming from the nose and struggling to breathe by the 22-year-old father. The 18-year-old mother, a youth in care, gave the infant to the father earlier that day for their first visit together. The father reported that the infant was fussy and diffucult to console for the remainder of the evening. The father called 911 just after midnight because the infant appeared to have difficulty breathing. Emergency medical services transported the infant to the hospital where the infant was subsequently pronounced deceased. Upon examination, the infant had sustained multiple skull fractures. There were multiple caregivers involved with the infant in the days prior to the death, therefore an allegation of head injury was indicated to an unknown perpetrator. The autopsy revealed the cause of death as interstitial pneumonia, and allegations for death by abuse against both parents were unfounded. While the mother was initially arrested for the child's death, no criminal charges were filed after the autopsy revealed the head injuries did not contribute to the infant's death.

INVESTIGATION

The Department removed the mother from her home at 3 years old after she sustained burns that were determined to be abusive. The mother remained in care until she was adopted at age 6. The mother's adoption disrupted in 2015 when the mother was 14 years old and she re-entered care. While in care, the mother had several placements, including a group home. The mother eloped from her placement on more than one occasion and stayed with relatives, including the adoptive mother. Approximately seven months prior to the infant's birth, the mother disclosed her pregnancy to her caseworker. The mother was then placed in a residential facility that specialized in providing services to pregnant and parenting youth in care. In the months prior to giving birth, the mother participated in services as required by the Hill Consent Decree. After giving birth, the mother and infant were assessed, and it was determined that the mother properly fed and comforted the infant and was provided with additional education. When the infant was 6 weeks old, residential staff provided care for the infant after the mother placed the crying infant in the hallway in a bouncy seat. The mother later reported to staff a desire to place the infant in a dumpster, and staff expressed concern about the mother's mental health. Residential staff planned to monitor the mother and infant more closely, including overnight safety checks. The incident was reported to the State Central Register and accepted as information only. In an interview with OIG staff, management at the State Central Register stated that the call should have been accepted for investigation, and that a reporter may request a supervisory review if a call is not accepted for investigation. The call-taker of this report was provided with supervision and education on clinical assessment skills.

On the morning prior to the infant's death, the caseworker observed the mother soothing the infant and reported to the caseworker that the infant ate approximately every three hours. Later that day, residential staff noted the mother left the facility with the infant, but the infant was not in her care upon the mother's return that evening. The mother reported to residential staff that she left the infant with the grandmother, however the mother later reported that she allowed the infant's father to care for the infant overnight because she was tired. The father reported to law enforcement that he picked up the infant from the mother for his first visit on the evening prior to the death. Residential staff told OIG investigators that because the infant was not in the care of the Department, staff only provided advice on care and supervision. However, residential protocol for a child of a youth in care visiting an individual outside of the facility required staff to conduct a background check on the individual. It was reported that the mother knew the protocol and the grandmother previously passed a background check prior to caring for the infant.

RECOMMENDATIONS

1. The report should be shared with the Teen Parent Service Network for training purposes.

The Department agrees. The Office of Education and Transition Services shared the redacted report with the Teen Parent Service Network and included recommendations offered by Division of Monitoring.

2. The report should be shared with the assigned private agency. Administration should assure staff that when calling in a report, if the call-taker does not initiate an investigation and they believe that call should be taken for investigation, they should ask for a State Central Register supervisory review.

The Department agrees. A redacted report was shared with the agency.

DEATH AND SERIOUS INJURY INVESTIGATION 12

DEATH

A 5-month-old was found unresponsive by the 21-year-old mother and 34-year-old father. The infant was transported to the hospital and pronounced deceased. Autopsy revealed the cause of death was viral pneumonia with focal streptococcus pneumoniae bacterial infection. The Department unfounded allegations against the parents for death by neglect to the infant and substantial risk of injury to the 4-year-old and 5-year-old siblings. During the pending death investigation, the Department received a subsequent oral report alleging domestic violence between the parents and the case was referred to the State's Attorney's Office.

INVESTIGATION

Approximately nine months prior to the death of the infant, the Department initiated an investigation after a report of domestic violence when the father struck the mother and then placed a firearm to his head and threatened suicide. The mother's two children from a different relationship, a 3-year-old and 4-year-old, reported witnessing the event but denied the father ever hurt them. During the pending child protection investigation, the mother reported ending their relationship and no longer cohabitating. The mother acknowledged understanding that any future domestic violence placed her children at risk and may result in court involvement or loss of custody. The father denied using a firearm, threatening suicide or being abusive towards the mother. The father reported to the child protection investigator the couple planned to reunite after closure of the child protection investigation. While the child protection investigator determined that the father was the aggressor, the child protection investigator believed the father was an ineligible perpetrator. The child protection investigator based the decision to unfound the investigation on the mother's lack of history of domestic violence or child abuse and neglect. Additionally, the mother acted to mitigate the risk to her children.

Five months later, the Department provided intact family services to the father's children with a different mother, who were ages 5 and 3. The Department indicated an allegation of risk of harm against that mother because of domestic violence in a different relationship. While the father was listed as a parent in the case, no services were offered, and the father did not participate in the case. The father's children remained with their mother and the case was closed four months later.

The infant's mother alleged the child protection investigator assigned to the death investigation failed to explain the purpose and intent of intact services, consequences for not participating in services, and misidentifying safety plan paperwork presented to the mother for signature. During an OIG investigation, it was determined that the child protection investigator conducted multiple calls and visits with the mother explaining the nature of services and the purpose of safety planning with the family. The assigned supervisor reported to OIG investigators that the mother's reluctance to participate in services was a direct influence of the father who the Department recommended not live in the home with the mother. The father continued to challenge the need to address domestic violence, which he denied. The supervisor also met with the family and explained the Department's decision-making process, possible outcomes, and that the children had been assessed safe in her care regardless of her participation in intact services. The OIG investigation did not find any instances of malfeasance or misfeasance by the assigned child protection investigator or supervisor and no further action was warranted.

RECOMMENDATIONS No recommendations were made to the Department.

DEATH AND SERIOUS INJURY INVESTIGATION 13

DEATH A 2-month-old infant was pronounced deceased at the hospital after being born premature with medical complications. The infant never left the hospital and the Department received notification of the death.

INVESTIGATION The mother's family had prior involvement with the Department beginning when the mother was 1 year old and multiple investigations of neglect were unfounded over the next three years. The mother's stepfather was later indicated for inadequate supervision when a sibling fractured an arm. The same stepfather was indicated seven years later for substantial risk to the mother in two separate investigations.

The Department's initial contact with the 16-year-old mother as a parent occurred in 2018 after a report that she shook and struck the then 3-month-old sibling. The mother had a history of mental health issues, psychiatric hospitalizations and medication non-compliance that impacted her behavior. The child protection investigator observed the sibling to be safe while in the care of the maternal grandmother. The mother reported she stopped taking her medication when she became pregnant and while nursing. During the investigation, the child protection investigator encouraged the grandmother to pursue legal guardianship of the infant through probate court. Throughout the investigation, the sibling remained in the care of the maternal grandmother. The investigation was subsequently unfounded for risk of harm against the mother.

The Department initiated a second child protection investigation less than three weeks after the previous investigation was closed when the mother attacked the sibling's babysitter and threatened self-harm. Concerns about the mother's medication compliance were expressed again. The Department received a related information report after the mother, who was pregnant with her second child, expressed self-harm to herself and her unborn child. The mother agreed to allow the maternal grandmother to seek guardianship of the then 8-

month-old sibling through court, but the guardianship was not completed during the investigation. The sibling's primary care provider reported no concerns and both the mother and grandmother were engaged in community services. The investigation was closed as unfounded against the mother for neglect.

A third investigation was initiated two months later involving the maternal grandmother and stepgrandfather. The then 1-year-old sibling reportedly fell out of a high chair under the supervision of the maternal step grandfather, who denied the sibling fell. There were concerns about the stepgrandfather's use of alcohol while caring for the sibling. The maternal grandmother agreed to no longer allow the step grandfather to care for the sibling. During the pending investigation, the mother gave birth to her second child, who was born premature, required continued hospitalization, and was on a respirator. The newborn's medical team expressed concern about the mother's ability to make healthcare decisions because she did not appear to understand the seriousness of the newborn's medical needs. The maternal grandmother, who obtained guardianship of the sibling, planned to obtain guardianship of the newborn. The grandmother reported difficulty with hospital staff and felt they encouraged her to remove the newborn from medical care. The grandmother had difficulty accepting the death of the newborn. The child protection investigator told OIG investigators that the grandmother appeared sad and overwhelmed but appropriate. The supervisor told OIG investigators that hospital staff treated the grandmother harshly. The supervisor reported consulting with the Area Administrator on this investigation because of the difficulty between the hospital and the family. The allegations of neglect against the maternal grandmother and step grandmother were unfounded.

A fourth investigation was initiated during the pending third investigation involving supervision issues when it was reported that the grandmother left the mother at the hospital with no transportation. Both the mother and the grandmother reported a miscommunication and the allegation against the grandmother was subsequently unfounded.

OIG determined that the Department acted appropriately.

RECOMMENDATIONS No recommendations were made to the Department.

PART II: CHILD DEATH REPORT

OIG investigates the deaths of children whose families were involved in the Illinois child welfare system within the preceding 12 months. OIG staff receive notification of the death of a child from the Illinois State Central Register (SCR), when the death is reported to SCR.[1] OIG staff investigate the Department's involvement with the deceased and his or her family when (1) the child was a youth in the care of DCFS; (2) the family is the subject of an open investigation or service case at the time of the child's death; or (3) the family was the subject of an investigation or service case closed within the preceding 12 months. Whenever OIG investigators learn of a child death meeting these criteria, the death is investigated.[2]

Notification of a child's death initiates an investigatory review of records. OIG investigators review the death reports and information available through the Department's computerized records. The investigator then obtains additional records, including the child's autopsy reports.[3] Records may be requested, impounded, or subpoenaed. The majority of cases involve an investigatory review of records, often including social service, medical, police, and school records, in addition to records generated by the Department or its contracted agencies.

When warranted, OIG investigators conduct a full investigation, including interviews. A full investigation may result in a report to the Director of DCFS. Individual cases may not rise to a level necessitating a full investigation, but collectively can indicate systemic patterns or problems that require attention. OIG staff may address systemic issues through a variety of means, including cluster reports, initiatives, and trainings.

In Fiscal Year 2021, OIG investigated 122 deaths of children who died between July 1, 2020 and June 30, 2021, meeting criteria for review. A description of each child's death and DCFS involvement is included in this Annual Report. During this fiscal year, an investigatory review of records was conducted in each of the 122 deaths, leading to 23 full investigations. Twenty of those investigations are pending. Comprehensive summaries of death investigations reported to the Director in FY 2021, which may include deaths that occurred in earlier fiscal years, are included in Part I: Death and Serious Injuries Investigations.

Seventy-eight of the 122 child deaths reviewed by OIG also underwent a child protection investigation of the death. Twenty-eight deaths (36%) were indicated, 32 (41%) were unfounded and 18 (23%) remain pending. Seventeen of the deaths were ruled homicide in manner. Seventeen deaths had an undetermined manner. Twenty-six deaths had a manner of accident. Forty-five deaths had a manner of natural causes. Eight deaths had a manner of suicide. Autopsy results have not been released for nine deaths.

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[1] SCR relies on coroners, hospitals, medical examiners and law enforcement to notify them of child deaths, even when deaths are not suspicious for abuse or neglect. Some deaths may not be reported. As such statistical analysis of child deaths in Illinois is limited because there is no central repository that includes the total number of children that die in Illinois each year. The Cook County Medical Examiner's policy is to notify the Department of the deaths of all children autopsied at the Medical Examiner's office.

[2] Occasionally, SCR will not receive notice of a child death and OIG staff learn of it through other means.

[3] OIG acknowledges all the county coroners and the Cook County Medical Examiner's Office for responding to our requests for autopsy reports.

SUMMARY

Following is a statistical summary of the 122 child deaths reviewed by OIG in FY 2021, as well as summaries of the individual cases. The first part of the summary presents child deaths by age and manner of death, case status and manner of death, county and manner of death, and child protection death investigations by result and manner. The second part presents a summary of deaths classified in five manners: homicide, suicide, undetermined, accident, and natural.[4] This year there are nine deaths where autopsy results have not yet been released and thus this report has a list of deaths classified under an added pending classification section. Please note that the term "coroner" is used for both coroners and the Cook County Medical Examiner in the individual summaries.

Key for Case Status at the time of OIG investigation:

Youth in Care	Deceased was a Youth in Care.
Unfounded DCP	Family had an unfounded child protection investigation within a year of child's death.
Pending DCP	Family was involved in a pending child protection investigation at time of child's death.
Indicated DCP	Family had an indicated child protection investigation within a year of child's death.
Child of Youth in Care	Deceased was the child of a youth in care, but not in care themselves.
Open/Closed Intact	Family had an open intact family services case at time of child's death / or within a year of child's death.
Open Placement/Split Custody	Deceased, who never went home from hospital and had sibling(s) in foster care, or child was in care of parent with siblings in foster care.
Return Home	Deceased or sibling(s) returned home to parent(s) from foster care within a year of child's death.
Child Welfare Services Referral	A request was made for DCFS to provide services, but no abuse or neglect was alleged.
Preventive Services/Extended Family	Intact family services case was opened to assist family, but not as a result of an indicated child protection investigation.
Former Youth in Care	Child was a youth in care within a year of his/her death.

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

Table 1: Child Deaths by Age and Manner of Death

Child Age		Homicide	Suicide	Undetermined	Accident	Natural	Pending	TOTAL
Months of Age	At birth					5	1	**6**
	0 to 3	2		11	5	11	3	**32**
	4 to 6	1		4		2	2	**9**
	7 to 11	1			2	1	1	**5**
	12 to 24			1	5	3	1	**10**
Years of Age	2				3	3		**6**
	3				1	5		**6**
	4	1				2		**3**
	5	1				2		**3**
	6	1			1	1		**3**
	7	2						**2**
	8					1	1	**2**
	9		1	1	1	2		**5**
	10	1						**1**
	11	1				1		**2**
	12		1					**1**
	13				1			**1**
	14	2	2		1	2		**7**
	15				2	3		**5**
	16	1	2		1	1		**5**
	17	2	1		2			**5**
	18 or older	1	1		1			**3**
TOTAL		**17**	**8**	**17**	**26**	**45**	**9**	**122**

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

Reason for OIG investigation*		Homicide	Suicide	Undetermined	Accident	Natural	Pending	TOTAL
DCP	Pending	3		2	6	7	2	**20**
	Unfounded	6	3	6	8	21	1	**45**
	Indicated	2	2	1	4	4	1	**14**
Youth in Care		2	1	1	2	5		**11**
Open Placement		1	1	1		2	3	**8**
Closed Placement							1	**1**
Open Intact		3		3	3	4	1	**14**
Closed Intact				2	2	2		**6**
Return Home			1		1			**2**
Split Custody				1				**1**
TOTAL		**17**	**8**	**17**	**26**	**45**	**9**	**122**

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

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

County	Homicide	Suicide	Undetermined	Accident	Natural	Pending	TOTAL
Champaign				2			**2**
Christian		1	1				**2**
Clay					1		**1**
Coles					1		**1**
Cook	8	5	7	4	15	4	**43**
Dekalb					2		**2**
DuPage	1			1			**2**
Edgar			1				**1**
Fayette					1		**1**
Franklin				2			**2**
Fulton					1		**1**
Grundy				1			**1**
Henry				1			**1**
Iroquois				1			**1**
Jackson				1			**1**
Jefferson					2		**2**
Kane	1				2	1	**4**
Kankakee					1		**1**
Kendall	1						**1**
Lake	1		2		1		**4**
LaSalle				2			**2**
Macon				1	1		**2**
Macoupin					1		**1**
Madison					1	1	**2**
Marion					1		**1**
McDonough					1		**1**
Monroe					1		**1**
Montgomery			1		2		**3**
Morgan		1					**1**
Ogle	1						**1**
Peoria			2	2	1		**5**
Randolph				1			**1**
Rock Island	1				1		**2**
Sangamon			1	1			**2**
St. Clair	2			2	4	2	**10**
Tazewell	1						**1**
Whiteside			1				**1**
Will			1	2	1		**4**
Winnebago		1		2	2	1	**6**
Woodford					1		**1**
TOTAL	**17**	**8**	**17**	**26**	**45**	**9**	**122**

TABLE 4: CHILD PROTECTION DEATH INVESTIGATIONS BY RESULT AND MANNER*

FINAL FINDING	HOMICIDE	SUICIDE	UNDETERMINED	ACCIDENT	NATURAL	PENDING	TOTAL
Indicated	7		6	12	3		**28**
Unfounded		1	7	7	17		**32**
Pending	2		4	2	2	8	**18**
TOTAL	**9**	**1**	**17**	**21**	**22**	**8**	**78**

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

FY 2021 DEATH CLASSIFICATION BY MANNER OF DEATH

HOMICIDE

Seventeen deaths were classified as homicide in the manner of death.

CAUSE OF DEATH	NUMBER
Abusive trauma	3
Drug toxicity	2
Gunshot wound(s)	7
House fire	1
Stab wound(s)	2
Suffocation	2
TOTAL	**17**

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ALLEGED PERPETRATOR INFORMATION*

PERPETRATOR	NUMBER
Mother	4
Stepfather	1
Mother's paramour	1
Unrelated person	6
Unknown/unsolved	3
Criminal investigation pending	3

**Some deaths have more than one perpetrator*

UNDETERMINED

Sixteen deaths were classified undetermined in the manner of death.

CAUSE OF DEATH	NUMBER
Undetermined	10
Undetermined – sleep related	3
SIDS/SUID	3
Pneumonia	1
TOTAL	**17**

ACCIDENT

Twenty-six deaths were classified as an accident in the manner of death.

CAUSE OF DEATH	NUMBER
Blunt force trauma	1
Dog bite	1
Drowning	2
Drug overdose	2
Gunshot wound	1
House fire related	3
Ligature strangulation	1
Motor vehicle accident related	7
Sleep related	7
Pending cause	1
TOTAL	**26**

NATURAL

Forty-five deaths were classified natural in the manner of death.

CAUSE OF DEATH	NUMBER
Bacterial infection	1
Cancer	1
Chronic respiratory illness/ asthma/ pneumonia	6
Complications of cardiac illness	1
Complications of intestinal obstruction	1
Complications of neurological event	1
Complications of sepsis	5
Complications related to cerebral palsy	3
Complications related to diabetes	1
Complications related to prematurity	7
Complications related to transplant rejection	1
Congenital abnormalities/ chronic progressive illness/ genetic disorder	10
Liver failure	1
SIDS/SUID	2
Viral infection	3
Undetermined	1
TOTAL	**45**

SUICIDE

Eight deaths were classified as suicide in the manner of death.

CAUSE OF DEATH	NUMBER
Drug overdose	1
Hanging	4
Gunshot wound	1
Pending cause	2
TOTAL	**8**

HOMICIDE

Child No. 1	DOB: 02/2014	DOD: 07/2020	Homicide
Age at death:	6 years		
Cause of death:	Olanzapine toxicity		
Alleged perpetrator:	Mother and stepfather		
Reason for review:	Open intact family services case at time of child's death; three unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation; report to Director June 30, 2021 **See Death and Serious Injury Investigation 1**		

Narrative: Six-year-old was found unresponsive by her mother and stepfather. Paramedics and police reported she was in her bed, wearing only a diaper, with blood on her face. Her stepfather reported he had checked on her 10 minutes earlier and she was still breathing, though paramedics reported she appeared stiff as if she had been deceased much longer. The mother and stepfather both admitted to police that they gave her the mother's prescription medication to make her sleep. The Department indicated the mother and stepfather for death, death by neglect, medical neglect, environmental neglect, and substantial risk of physical injury/environment injurious to health and welfare by neglect. The mother and stepfather have been criminally charged in her death.

Prior History: In November 2019, the Hotline received a report that the child had been coming to school dirty and smelling like urine since the beginning of the school year, the family home was dirty, and the home had animal urine and feces in the living room. A related report stated the child had medical issues that her pediatrician recommended she see a specialist for, but her parents never took her to a specialist. The investigation was unfounded for environmental neglect. In January 2020, eight days after the previous investigation was unfounded, DCFS opened an investigation after the Hotline received a report that the child had accidents at school almost daily and arrived at school that day dirty, with greasy hair, and smelled strongly of musk, urine, smoke, and possibly animal waste. In February 2020, while the previous investigation was still pending, DCFS opened another investigation after the Hotline received a report that the child reported pain in her vaginal area, was dirty, and the reporter suspected the child's mother misused pain medication prescribed to the child's maternal grandmother. When the child protection investigator interviewed the family, the child reported she had no pain, she had been freshly bathed, and the home was cleaner than before. The child's pediatrician examined the child and found no rash or discharge, but informed the child protection investigator of the other underlying issues the child had, for which she had referred the child to specialists, and the family was not consistent with keeping appointments. The pediatrician felt this was not intentional medical neglect, but the family needed help in the home and with transportation. In March 2020, the Department unfounded the January 2020 investigation for environmental neglect. The child protection investigator on the February 2020 investigation discussed intact family services for the family and submitted a referral. In April 2020, when the child's school transitioned to remote learning due to the COVID-19 pandemic, the child did not attend remote sessions and was not completing any assigned schoolwork. That month, the intact family services cases was assigned, and the transitional visit occurred. In May 2020, the child protection investigator reported that the child and her sister were being bathed regularly, collaterals reported no concerns, and the child's pediatrician reported no concerns of medical neglect. The investigation was unfounded for medical neglect, inadequate clothing, and substantial risk of physical injury/environment injurious to health and welfare by neglect. At the time of the child's death, the intact worker was in the process of completing the integrated assessment.

Child No. 2	DOB: 01/2013	DOD: 07/2020	Homicide
Age at death:	7 years		
Cause of death:	Gunshot wound to the head		
Alleged perpetrator:	Unrelated adults		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-year-old was struck by a bullet to her forehead. She and her family were attending a birthday party at her grandmother's home, and she was playing in the front yard, when a car stopped at the next house and three men in the car began shooting into the crowd. The child was taken to the hospital and intubated but medical staff were unable to resuscitate her. Four men have been charged with first degree murder for her death. The Department did not investigate her death.

Prior History: Between 2014 and 2017, the Department opened seven investigations against the mother. The mother was indicated in three investigations for allegations including inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. The Department had offered the mother intact family services following the 2014 investigation, but the mother refused. The Department opened an investigation in 2017 when police were called because of domestic violence between the mother and her then partner. The children went to live with their father. In January 2020, the Hotline received a report the father hit the then 8-year-old brother. The then 7-year-old child, her brother, and their then nine-year-old sister were living with their aunt while in school, but visited their father and his paramour. Their mother was incarcerated. The girls reported they were spanked, had time outs, or were denied candy when they got in trouble, but had never been hit with belts or other objects, and had never seen their brother hit with a belt. The brother reported he had been spanked with a belt once or twice. The girls were observed to be free of marks and bruises, and their brother had a scratch on his face he said he got from his sister. The children's grandmother, aunt and pediatrician denied any concerns. The investigation was unfounded, and the father received referrals for family advocacy.

Child No. 3	DOB: 03/2003	DOD: 07/2020	Homicide
Age at death:	17 years		
Cause of death:	Gunshot wound of the chest		
Alleged perpetrator:	Unknown		
Reason for review:	Open placement case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was found lying on the pavement and pronounced deceased at the scene by EMS personnel responding to shots fired around 9:49pm. According to law enforcement, the teenager was shot while attempting a carjacking. The Department did not investigate the death.

Prior History: In August 2018, the Hotline received a report that the teenager's then 10-year-old sister said she was afraid to go home and had pain, burning, itching, and bleeding in her genital area. She reported that a boy had been watching her one night and touched her inappropriately, but when she told her mother about the incident, her mother punished her. The mother reported she was homeless, she and the 10-year-old were staying with a friend of hers, the then 15-year-old teenager was living with an aunt, and the teenager's then 7-year-old sister was staying with a family friend. The mother agreed to have the 10-year-old stay with her godmother until a forensic interview could be scheduled. The godmother though returned the 10-year-old to her mother, so the Department took protective custody of the 10-year-old and the 7-year-old sister. The investigator interviewed the then 15-year-old teenager, who said he felt safe at his aunt's home and the aunt stated she did not need help from the Department. The Department indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect. The investigation was unfounded for medical neglect, inadequate supervision, and sexual penetration. The mother had supervised visits with the younger children and was referred for services including a substance abuse assessment, which indicated she did not need services; parenting classes, which she completed; and

mental health services, which she did not consistently attend. The teenager's younger siblings participated in counseling. In April 2020, the mother gave birth, and the Department opened an investigation due to the open placement case. The baby boy was placed in a fictive kin foster home. In June 2020, the mother signed over guardianship of the teenager's sisters.

Child No. 4	**DOB: 02/2016**	**DOD: 07/2020**	**Homicide**
Age at death:	4 years		
Cause of death:	Multiple fractures and visceral injuries due to blunt trauma of torso and head		
Alleged perpetrator:	Mother's paramour		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation; report to Director May 7, 2021 **See Death and Serious Injury Investigation 10**		

Narrative: Four-year-old found unresponsive at home. Paramedics attempted to resuscitate him for approximately 40 minutes, but the toddler never regained a pulse and was pronounced deceased at the scene. He was found to have significant trauma, including facial injuries, lacerations to multiple internal organs, and five broken ribs. DCFS took the toddler's 1-year-old sibling into protective custody. The Department indicated the toddler's mother and her paramour for death by abuse, environmental neglect, and substantial risk of physical injury/environment injurious to health and welfare by neglect. The mother's paramour has been charged with first degree murder.

Prior History: In 2018, the mother came to the attention of DCFS after her grandmother made three requests for assistance in obtaining guardianship of the toddler. In November 2019, the Department investigated the mother for environmental neglect to her two children after a Hotline report that the mother was not providing appropriate care for the toddler and his then 7-month-old brother, and the home was infested with cockroaches. The investigation was unfounded in January 2020.

Child No. 5	**DOB: 10/2019**	**DOD: 09/2020**	**Homicide**
Age at death:	10 months		
Cause of death:	Hypoxic ischemic encephalopathy due to suffocation		
Alleged perpetrator:	Mother		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation; report to Director in FY 2022		

Narrative: Ten-month-old's mother called 911 and stated the infant was choking. Paramedics found the infant unresponsive, began CPR, and transferred her to the hospital where she was placed on a ventilator. DCFS took custody of the infant's brother and maternal half-brother. The infant was pronounced deceased three days later. The mother initially stated the infant was having a tantrum, so she gave the infant a waffle, which the infant choked on. The mother later admitted she held the infant against her body until the infant stopped moving, then the mother fell asleep. She stated she awoke a few minutes later and found the infant was not breathing. The Department investigated the infant's death and indicated the mother for death by abuse, and indicated both parents for tying/close confinement and substantial risk of physical injury/environment injurious to health and welfare by neglect. The mother was charged with involuntary manslaughter.

Prior History: In March 2020, the Hotline received a report that the infant's 2-year-old maternal half-brother had bruises from the stepfather spanking him, the grandfather would blow marijuana smoke in the brother's face, and the parents left the brother in his playpen all day allowing him to cry until he fell asleep. The parents both disclosed a history of health conditions and the child protection investigator discussed community resources with the parents. In May 2020, the Department unfounded the investigation. In July 2020, the Hotline received a report that the 2-year-old maternal brother was taken to the hospital by ambulance. The mother reported she spanked him on his buttocks, left the room to check on the infant,

heard a thump, and found the 2-year-old having seizure-like activity and his eyes were rolling back. She reported that when she disciplined him in the past by spanking him, he had "tremors," but she had not sought medical attention. She stated she usually disciplined the brother by taking away games or using time outs. The parents informed the child protection investigator they were involved with community resources. In August 2020, DCFS unfounded the investigation.

Child No. 6	**DOB: 07/2015**	**DOD: 09/2020**	**Homicide**
Age at death:	5 years		
Cause of death:	Multiple incised wounds to neck		
Alleged perpetrator:	Mother		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-year-old was stabbed in the neck by her mother. Police arrested the mother and charged her with homicide. The Department investigated the death and indicated the mother for death by abuse to the child and substantial risk of physical injury/environment injurious to health and welfare by abuse to the child's surviving 8-year-old sister.

Prior History: In July 2020, the Hotline received a report that the child was running around the neighborhood unattended. The mother was running errands and stated she left the child with another adult in the home. The other adult stated he was asleep at the time the mother left, and the mother did not inform him she was leaving the child in his care. The child stated she did not see anyone home when she awoke, so she went outside to look for her mother and the door locked behind her. The Department indicated the mother for inadequate supervision. The Department attempted to contact the mother to offer community services, but she had moved, and her phone was not accepting voicemail messages.

Child No. 7	**DOB: 08/2004**	**DOD: 12/2020**	**Homicide**
Age at death:	16 years		
Cause of death:	Gunshot wound to the abdomen		
Perpetrator:	Unrelated adult		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old and two adult men were found critically wounded when police responded to reports of a shooting. The teen and one of the men were pronounced deceased at the hospital. A police investigation indicated that the teen and the other man who died shot each other, and the case was closed with no further charges. Police reported the shooting appeared to be related to a robbery. The Department did not investigate the teen's death.

Prior History: In 2016, the teen was an unfounded victim in two investigations at the residential treatment facility where he resided. In May 2019, following an unfounded investigation the Department opened an intact family services case that included therapy, Norman Funds and a referral for housing advocacy so the family could find a larger apartment, and bus passes for the mother to visit the teen, who at that time, was incarcerated for assault. In August 2019, the teen was released and came into the care of DCFS for behavioral issues. He was placed with his aunt, but was briefly detained by police in September 2019 for stealing a car. In October 2019, the teen went on run and remained missing until November 2019, when he was arrested for car theft. For the following year, he remained in detention in different locations. In March 2020, the teen agreed to a plea deal for felony car theft in which the owner was injured. He remained in detention. In November 2020, he was released to the care of his maternal aunt, awaiting opening at a residential center. The caseworker and the teen's probation officer had difficulty reaching the teen and his aunt reported he refused to take his medication and did not follow rules. Nine days before his

death, the teen left his aunt's home; his mother and the caseworker filed a missing person's report. The teen did not return to his aunt's home prior to his death.

Child No. 8	**DOB: 06/2006**	**DOD: 12/2020**	**Homicide**
Age at death:	14 years		
Cause of death:	Stab wound of the chest		
Perpetrator:	Unrelated adult		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old was stabbed by an 18-year-old woman. Emergency responders transported the teen to the hospital where she was pronounced deceased. The Department did not investigate the teen's death for abuse or neglect.

Prior History: In 2019, the mother was indicated for sexual exploitation to the then 13-year-old teen, her 15-year-old sister, and her 8-year-old brother following allegations the parents were involved in prostitution. Both parents were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect. The children had been staying out of state with an aunt at the time, and she completed temporary guardianship paperwork. In January 2020, the Hotline received a report that the teen went back to live with her father, and the reporter learned the mother was living in the home despite the previous indicated finding of sexual exploitation. The teen and her father denied the mother lived there, and the teen denied she had recently seen her mother. The Department unfounded the investigation due to a lack of evidence the mother lived in the home. In September 2020, the Hotline received a report that all three children returned to their father's care, the father had allowed the mother to spend the night in his home and care for the children unsupervised and the mother was using substances. The father also was reportedly allowing the children to use substances and drink in the home and the children were not enrolled in school. It was also alleged that the father had a new paramour who was a prostitute who had taken the then 14-year-old teen and her 16-year-old sister to a home to make them sleep with men for money and drugs. The father denied the allegations, and the teen and her siblings denied anything inappropriate in forensic interviews. Oral swab drug testing came back negative for all three children and the father. In November 2020, the Department unfounded the investigation.

Child No. 9	**DOB: 10/2003**	**DOD: 01/2021**	**Homicide**
Age at death:	17 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unrelated adult		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was shot multiple times in the early morning. The teen was driving in a stolen car, and the owner of the car followed the car until it stopped in a parking lot. The teenager and another youth exited the car and began running away, and the owner of the car threatened to shoot them if they did not get on the ground. The owner of the car opened fire and struck the teenager three times; he was arrested and charged with the teenager's death.

Prior History: In September 2020, the hotline received a report after police responded to a 911 call that the then 16-year-old teen and his father had gotten into a physical altercation. The teen and his twin brother left the home and police found them a few blocks away. Police noted the father appeared unstable and angry. The teen's brother reported their father had been drinking alcohol earlier that day. The teen was taken to a local hospital and treated for a broken nose, and the father refused to pick him up from the hospital. The teen reported his father had never hit him prior to this incident, and he was not afraid of his father. He stated his father got angry when he did not stop playing video games, and unplugged his gaming

console. The teen then struck his father, and his father hit him back, breaking his nose. The teen's brother identified an adult friend they could stay with. The child protection investigator attempted to interview the father, but he denied entrance to the home and appeared intoxicated and agitated. He agreed to let the teen and his brother stay with their friend. The following day, the father allowed the teens to return home. Throughout the investigation, the teen and his brother repeatedly ran away from home. The Department indicated the father for cuts, welts, bruises, abrasions, and oral injuries by abuse; bone fractures by abuse; and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 10	**DOB: 11/2002**	**DOD: 01/2021**	**Homicide**
Age at death:	18 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Eighteen-year-old was a passenger in a car when gunfire erupted between the vehicle she was in and another vehicle. Police responded to the scene and discovered the teen and the driver unresponsive in the vehicle. She was transported to the hospital where she was pronounced deceased. The Department did not investigate the teen's death.

Prior History: In 2018, the Department took the then 15-year-old teen and her then 12-year-old brother into care after a physical altercation between the teen and her mother. The teen and her brother had multiple placement disruptions, and their mother was incarcerated during much of the placement case. In August 2020, the teen was moved from a fictive kin home to her maternal grandmother's home with her brother, and resided in her maternal grandmother's home until her death.

Child No. 11	**DOB: 09/2013**	**DOD: 02/2021**	**Homicide**
Age at death:	7 years		
Cause of death:	Suffocation		
Alleged perpetrator:	Mother		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Seven-year-old's mother reported she found him in his bed, not breathing. His mother called for an ambulance, and first responders pronounced him deceased at the scene. The child's father had sole custody of him, granted by the court in 2019, though his parents lived together. The Department indicated the mother for death by neglect. The mother has been charged with first degree murder and aggravated battery to a child.

Prior History: Between September 2018 and August 2020 there were five unfounded child protection investigations on the parents, several involving mother's substance abuse and mental health issues. In August 2020, the mother was investigated for substantial risk of physical injury/environment injurious by neglect and inadequate supervision after an anonymous reporter called the hotline and reported that the child's mother was often intoxicated while caring for the 7-year-old child and his maternal half-sisters, ages 8 and 11. The two sisters lived with their father, visiting the mother on the weekends. The reporter stated the father is aware of the mother's substance use but allowed the mother to care for the children while he was at work. The father denied ever leaving for work while the mother was intoxicated, stated her prescribed medications did not affect her functioning, and she did not use illegal drugs. The child's sisters denied seeing their mother passed out or asleep when no other adults were in the home. They admitted riding their bikes to the park together and said they had a phone and knew to contact their mother or police in case of an emergency. The Department unfounded the investigation.

Child No. 12	DOB: 04/2010	DOD: 02/2021	Homicide
Age at death:	10 years		
Cause of death:	Inhalation injuries due to inhalation of products of combustion due to a house fire due to arson		
Alleged perpetrator:	Unrelated adult		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Ten-year-old girl and her mother died in a house fire. The child had been living with a relative until a few days prior, when the relative had to go on a trip and left the child with her mother. The home where the fire occurred had been deemed inappropriate in a prior investigation. There were no other children in the home at that time. Police arrested a man for arson and homicide. The Department indicated the mother for death by neglect.

Prior History: In October 2020, the Hotline received a report that the family home lacked heat and water, had a broken window, and was littered with dishes, trash, and beer cans. The child protection investigator observed the home was dirty, had broken windows, and lacked gas, but the electricity and water were on and the mother reported she was using an electric heater. The mother stated the child and her two siblings lived with relatives. The relatives confirmed this, and stated the mother did not have stable housing. The child protection investigator noted all three children appeared safe and healthy in the homes of relatives. The Department unfounded the investigation because the children did not reside in the home. In January 2021, the Hotline received a report that the child's 2-week-old niece, born to the child's then 15-year-old sister, was residing with the child's mother in an unsuitable home that lacked doors, had broken windows, was filthy and infested with roaches, and did not have running water. The child protection investigator observed the home to have windows and doors intact, but no one answered the door and the home appeared empty. Nine days before the child's death, a relative confirmed the child's sister and mother were living with her at a different address. The house fire occurred at the address the reporter originally gave; the child and her mother were at the home where the fire occurred. The 15-year-old sister and her daughter were not at the home when the fire occurred. The 15-year-old sister reported she gave guardianship of her infant daughter to her godmother in another state. Child services in the other state observed the godmother's home to be appropriate. In March 2021, the Department unfounded the investigation with the rationale that the infant was in the care of her godmother, and the infant's 15-year-old mother resided with another relative.

Child No. 13	DOB: 11/2020	DOD: 03/2021	Homicide
Age at death:	4 months		
Cause of death:	Blunt force head injuries		
Alleged perpetrator:	Criminal investigation pending		
Reason for review:	Open high-risk intact family services case at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unconscious and not breathing. Paramedics revived him and he was taken to the hospital, then airlifted to a children's hospital. Scans showed significant injuries to his central nervous system, and child abuse pediatricians suspected the injuries were a result of being shaken. Four days after his admission, he was pronounced deceased. The Department opened an investigation into the death and took the infant's twin into care. The investigation is pending for death by abuse against the infant's mother and father.

Prior History: In January 2021, the Hotline received a report that the infant's then 1-month-old twin sister was taken to the emergency room because she stopped breathing. She had a subdural hemorrhage with increased cranial fluid, three healing rib fractures, was below the first percentile for weight, and had

lost weight since her birth. The Department initiated an in-home safety plan for the infant which stated his maternal grandmother would stay in the home and supervise all contact between the twins and their parents. The paternal grandmother came from out of state to assist with the safety plan. A child abuse doctor informed the child protection investigator that the twin's issues were medical in nature, she had no concern regarding abuse, and the twin's skull fracture and hematomas likely resulted from a stroke in-utero or shortly after birth. The safety plan was terminated after the finding. The child abuse doctor later confirmed the twin had a clavicle fracture that was not present at her birth but was unable to determine its cause or whether abuse or neglect were involved because the bone was the size of a toothpick. The Department implemented another safety plan due to the unexplained injury. The safety plan was ended after the Division of Specialized Care for Children (DSCC) services, DCFS nursing, and intact services were in place. The twin was diagnosed with hydrocephalus, seizures, subdural hematomas, nystagmus, and dysphagia; was placed on multiple medications; and received a feeding tube before being released from the hospital. The Department opened a high-risk intact family services case in February 2021. The investigation was unfounded due to the child abuse doctor's findings.

Child No. 14	**DOB: 05/2009**	**DOD: 03/2021**	**Homicide**
Age at death:	11 years		
Cause of death:	Gunshot wound of face		
Alleged perpetrator:	Unrelated adults		
Reason for review:	Open intact family services case at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eleven-year-old was the passenger in a vehicle that was stopped at a gas station and was shot in a random act of violence. Her mother was driving the car and her siblings and her mother's paramour were also passengers. The child was on life support for three weeks until her death. Two people unrelated to the family have been arrested in connection to the case. The Department investigated the child's death and unfounded the investigation.

Prior History: In November 2020, the Hotline received a report that the child's then 12-year-old brother reported suicidal ideation and stated the mother wanted to hit him with household items. The Department indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect. In February 2021, DCFS opened intact family services to help the mother address the brother's needs. The intact family services case was open at the time the child died.

Child No. 15	**DOB: 02/2021**	**DOD: 04/2021**	**Homicide**
Age at death:	2 months		
Cause of death:	Closed head injury due to abuse		
Alleged perpetrator:	Criminal investigation pending		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Two-month-old presented to the hospital with a head injury and bruising to the face. Hospital staff believed the trauma was most likely related to abusive head trauma. The infant was listed in critical condition and transferred to a different hospital. Six days later, the infant was pronounced deceased. The mother reported she left the infant in the care of his father when she went to work, and found the infant lethargic and unable to eat when she arrived home. The father stated the infant's 1-year-old brother hit him in the face with a toy phone. The Department investigated the infant's death and indicated the infant's mother and father for death by abuse.

Prior History: In June 2020, the Hotline received a report that the father was sticking objects in the 6-year-old maternal brother's anus, the brother had scratches on his back in the shapes of numbers and letters

inflicted as brands, and the mother abused medications. The 6-year-old denied anyone touched him or made him feel uncomfortable. The investigator observed that the child did not have any signs of branding on him. The mother denied drug use, denied the allegations of branding, and denied any recent domestic violence incidents with the father. The mother agreed to intact family services. The father denied the allegations and stated they had been harassed by family of the 6-year-old's father. The father agreed not to have unsupervised contact with the brother. The brother participated in a forensic interview and made no outcry of abuse. DCFS reportedly denied the request to open the case for intact services. The investigation was unfounded due to insufficient evidence.

Child No. 16	**DOB: 04/2021**	**DOD: 05/2021**	**Homicide**
Age at death:	1 month		
Cause of death:	Combined drug (despropionyl fentanyl, fentanyl, and acetyl fentanyl) toxicity		
Alleged perpetrator:	Criminal investigation pending		
Reason for review:	Pending child protection investigation at the time of child's death		
Action taken:	Investigatory review of records		

Narrative: One-month-old was found unresponsive, sleeping in an adult bed with his father. His mother began CPR and the infant was transported to the hospital, where he was pronounced deceased. The Department opened an investigation for death by neglect against the father. The investigation remains pending after fentanyl was found in the infant's system at autopsy. It is unclear how the infant ingested fentanyl. A criminal investigation is also pending.

Prior History: Ten years earlier the mother had an intact case open with the Department because of substance abuse issues. The case closed when the child went to live with his father. One week after the infant was born, the Hotline received a report that the parents were having verbal altercations in the hospital and both had physical injuries. Hospital staff observed both parents sleeping on the floor and not attending to the infant. His mother tested positive for THC at his birth, but the infant tested negative. His mother was also prescribed suboxone during pregnancy for opioid treatment. The parents were involved in a suboxone program. The child protection investigator consulted with a domestic violence specialist who advised there was insufficient evidence to make a determination on the father, but recommended the child protection investigator give him the Illinois Domestic Violence Helpline and recommended the mother attend counseling and focus on safety planning. The child protection investigator observed a bassinet and other baby items in the home. The grandmothers were providing support in the home. Four weeks into the investigation, the infant died. The Department indicated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect because the parents engaged in domestic violence in the infant's hospital room.

Child No. 17	**DOB: 05/2007**	**DOD: 06/2021**	**Homicide**
Age at death:	14 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old was pronounced deceased at the hospital three days after she had been shot and admitted to the hospital. She had been walking with her boyfriend when three individuals approached and asked what gang she was in. When she responded, one of the individuals produced a gun and shot twice in her direction; one bullet hit her in the head. The Department did not investigate the teen's death.

Prior History: Between July 2009 and May 2017, the Department opened four investigations against the mother related to substance misuse; one was indicated and the other three were unfounded. Eight days before the teen was shot, the Hotline received a report that the teen was involved in a fight with a peer,

and the mother had transported her and her 6-year-old sister to the scheduled fight, watched the fight, and actively participated in it. The mother stated she was at a laundromat when the teen's 6-year-old sister told her someone was jumping on the teen, so she tried to break up the fight. She stated the peer's mother then began fighting with her, and she was defending herself. The mother took the teen and her sister to the hospital to be seen by a physician following the child protection investigator's instruction. Hospital staff reported the teen and her sister had lice and were covered in bug bites, though they had no infections from the insects; the teen had an open abrasion on her knee; and the children had missed multiple exams, though they did not have any chronic medical conditions. The investigation was pending at the time the teen was shot. The Department later indicated the investigation for environmental neglect due to the lice and bug bites and referred the family for community-based services.

SUICIDE

Child No. 18	DOB: 10/2010	DOD: 07/2020	Suicide
Age at death:	9 years		
Cause of death:	Anoxic brain injury due to hanging		
Reason for Review:	Indicated child protection investigation within one year of the child's death		
Action Taken:	Investigatory review of records		

Child No. 19	DOB: 02/2003	DOD: 09/2020	Suicide
Age at death:	17 years		
Cause of death:	Shotgun wound of the neck		
Reason for Review:	Unfounded child protection investigation within one year of child's death		
Action Taken:	Investigatory review of records		

Child No. 20	DOB: 07/2004	DOD: 09/2020	Suicide
Age at death:	16 years		
Cause of death:	Asphyxia due to hanging		
Reason for Review:	Two indicated child protection investigations with one year of child's death		
Action Taken:	Investigatory review of records		

Child No. 21	DOB: 03/2001	DOD: 11/2020	Suicide
Age at death:	19 years		
Cause of death:	Pending		
Reason for Review:	Youth in care		
Action Taken:	Investigatory review of records		

Child No. 22	DOB: 01/2006	DOD: 11/2020	Suicide
Age at death:	14 years		
Cause of death:	Hanging		
Reason for Review:	Unfounded child protection investigation within one year of child's death		
Action Taken:	Investigatory review of records		

Child No. 23	DOB: 01/2007	DOD: 01/2021	Suicide
Age at death:	14 years		
Cause of death:	Asphyxia due to hanging		
Reason for Review:	Open placement case at time of child's death; unfounded child protection investigation within one year of child's death		
Action Taken:	Investigatory review of records		

Child No. 24	DOB: 04/2008	DOD: 01/2021	Suicide
Age at death:	12 years		
Cause of death:	Bupropion intoxication		
Reason for Review:	Return home within year of child's death; one unfounded and one indicated child protection investigation within one year of child's death		
Action Taken:	Investigatory review of records		

Child No. 25	DOB: 08/2004	DOD: 05/2021	Suicide
Age at death:	16 years		
Cause of death:	Pending		
Reason for Review:	Unfounded child protection investigation within one year of child's death		
Action Taken:	Full investigation pending		

UNDETERMINED

Child No. 26	DOB: 08/2010	DOD: 07/2020	Undetermined
Age at death:	9 years		
Cause of death:	Bronchopneumonia; significant contributory condition: malnourishment		
Reason for review:	Closed high-risk intact family services case within one year of child's death; one indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-year-old medically complex child was having difficulty breathing. Mother called 911 and paramedics transported the child to the hospital, where she was pronounced deceased. The child was born at 25 weeks gestation, spent the first year of her life in the hospital, and required a tracheotomy and nasogastric feeding tube. She was deaf, non-verbal, and almost blind. Her diagnoses included cerebral palsy, failure to thrive, developmental delays, auditory neuropathy, and short bowel syndrome. At her death, she weighed 35 pounds, had extensive bruising, including a contusion on her left eye, the back of her head, and on her thigh; she also had sores on her back and spine area. The Department took the child's 2-year-old maternal sister into care. Following the death, mother gave birth to her third child, who also came into care. The Department opened an investigation into the death. The investigation is pending for death by neglect against the child's mother.

Prior History: In 2018, the mother and her paramour (the father of her younger children) were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect following a domestic violence incident. In July 2019, the mother was investigated for cuts, welts, and bruises after the hotline received a report that the then 8-year-old child had bruises. The mother reported the child had been learning sign language and would become angry or frustrated and hit herself when she was unable to communicate. School personnel and the pediatrician had also witnessed self-harming behavior. The pediatrician expressed concern about the mother's ability to keep appointments but did not believe the concerns rose to the level of medical neglect. The mother stated the child had trouble gaining weight since her birth and weighed between 28 and 32 pounds for the past few years. DCFS unfounded the investigation. The mother declined intact family services. In September 2019, the Hotline received a report that the child had missed two appointments with a gastrointestinal specialist. The mother stated the first appointment was canceled by the hospital, and she lacked transportation to attend the second appointment. The mother rescheduled the appointment while the child protection investigator was present and agreed to intact family services. In January 2020, the Department indicated the mother for medical neglect. The mother was cooperative with intact services and complied with the child's medical appointments and treatment. The worker followed up with minor's GI doctor and nutritionist on a regular basis. The mother was advised to do weight checks at home during COVID. The agency provided a weight scale and assisted mother with changing medical supply companies to meet the child's nutritional needs. The agency also assisted with protective day care for the younger child. The intact worker did not have concerns about the home environment and described it as relatively clean and was unaware of domestic violence or mental health issues. While the intact case was open, the mother was again investigated and unfounded for cuts, welts, and bruises to the child. In June 2020, the intact family services case was successfully closed.

Child No. 27	DOB: 05/2020	DOD: 07/2020	Undetermined
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	Three unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was found unresponsive by his mother, laying on a nursing pillow in a bed. His mother stated she checked on him approximately one hour earlier. The Department investigated the infant's death and indicated the mother for death by neglect because she placed him to sleep in a bed, on a pillow. The Department indicated both parents for substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant's siblings due to ongoing domestic violence.

Prior History: In August 2019, DCFS opened an investigation after police responded to a domestic violence complaint at the family home. The parents had a history of domestic violence and were in the process of divorcing. In September 2019, while the investigation was pending, another investigation was opened following a report that the infant's then 16-month-old brother had a bruise and was underweight; the father's home was dirty with diapers, beer bottles, moldy food, and cat feces throughout the home. In addition, the father reportedly withheld food as punishment to the infant's then 2-year-old and 5-year-old brothers. The children were observed to be free of signs of abuse or neglect, and the father's home was observed to be cluttered and messy, but free of visible safety hazards. The father reported he used time-outs and toy removal as punishment, and would refrain from spanking the children in the future. The pediatrician reported no concerns. The Department unfounded both investigations. In November 2019, the Hotline received a report that the infant's then 18-month-old brother was brought to the ER for a fever and looked malnourished. The treating hospital physician reported no concerns about abuse or neglect. The mother stated she took the brother to urgent care a few days prior, where he was diagnosed with adenovirus and was advised to keep him hydrated while the virus ran its course. She brought him to the emergency room following urgent care's instructions to do so if he did not improve after a few days. The child protection investigator observed the children to be free of signs of abuse and neglect, and none appeared malnourished, though the brother was small. His pediatrician's office reported he was meeting his milestones. The home was also observed to have adequate food. DCFS unfounded the investigation.

Child No. 28	DOB: 05/2020	DOD: 07/2020	Undetermined
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	One unfounded and one indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was found unresponsive by his mother in his bassinet with blood and mucus coming out of his nose and mouth. He was transported to the hospital and pronounced deceased. The mother had prescriptions for an opiate and a tranquilizer, and tested positive for opiates, tranquilizers, and marijuana. The father, who was at work at the time of the death, was reportedly in a Suboxone program and tested positive for opiates and marijuana and did not have a prescription for opiates. The Department investigated the death and indicated both parents for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Prior History: The parents were involved in two prior investigations. In November 2019, when the mother was pregnant with the infant, law enforcement contacted the Hotline to report the mother called police when the father went into a rage after discovering they were out of formula. She reported he pushed her down, swung the infant's then 10-month-old sister's car seat around, and broke a mirror. The father left the scene before police arrived. The mother reported the father used heroin and was high during the incident, and police reported she became uncooperative when told the father would be arrested. She told police she would bail him out of jail and deny the incident occurred. The following day, the mother told

the child protection investigator that the father had recently begun attending anger management classes and did not know what had made him so angry. She denied the police report, minimized the incident, and denied reporting the father was high on heroin; she stated he used heroin in the past and was on Suboxone. She later reported he may have been using Xanax at the time of the incident. The Department implemented an out-of-home safety plan with the maternal grandmother, prohibiting both parents from having unsupervised contact with the sister. The maternal grandmother reported she had never seen the mother and father fight, the mother was against the father using any drugs, and he had made great efforts to stop but struggled to do so. The father admitted he overreacted and yelled, but denied the allegations of pushing the mother, swinging the car seat around, and breaking the mirror. He reported he had gone through a drug treatment program and had not used since then. The father agreed to cooperate with intact family services. The Department ended the safety plan, noting the father only tested positive for substances he was prescribed, the parents had support of the maternal grandparents, both parents were in counseling and agreed to intact family services. When the parents then refused to cooperate with intact services the Department referred the parents to the court, but the State's Attorney declined to file a petition. In January 2020, the mother and father were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect. Two weeks after the investigation closed, the Hotline received a report the father appeared under the influence when he dropped the infant's then 1-year-old sister off at daycare a few days prior. Daycare workers in subsequent days did not have concerns. The child protection investigator made a good faith attempt to see the family at home, and was only able to reach the mother by phone, who refused to meet with the investigator. The investigator interviewed her by phone, and she reported she did not go forward with intact family services due to scheduling difficulties. Both parents stated the father was compliant with his drug treatment program, and both parents denied domestic violence and denied any substance use beyond what was already documented. The father's treatment provider confirmed the father was in compliance with the program. In March 2020, the investigation was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect due to lack of evidence to substantiate the allegation.

Child No. 29	**DOB: 05/2020**	**DOD: 08/2020**	**Undetermined**
Age at death:	3 months		
Cause of death:	Undetermined		
Reason for review:	Open intact family services case at time of child's death; two indicated child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unresponsive in bed with mother at approximately 3:00am. 911 was called and she was transported to the hospital, where she was pronounced deceased. The mother reported she did not use the portable crib for sleeping and she and the father usually co-slept with the infant and her twin brother. The Department investigated the infant's death and indicated the mother for death by neglect, environmental neglect, and substantial risk of physical injury/environment injurious to health and welfare by neglect. The infant's twin brother and 2-year-old brother came into care.

Prior History: In April and May 2019, DCFS opened two investigations of the family. The mother was indicated in both investigations for allegations including inadequate supervision, inadequate shelter, and substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant's then 1-year-old brother. In March 2020, the Hotline received a report that the infant's then 2-year-old brother was living with his father who had been arrested for domestic battery after throwing the brother to the ground. In May 2020, while the investigation was pending, the infant and her twin brother were born and DCFS opened a new investigation after the mother told hospital staff that she did not have custody of her two older children. The mother reported that one of her children was with his biological father and her other child was with his maternal great grandmother. The mother stated she planned to stay with her sister while she healed from childbirth, then she and the father would move out of state with the children to live

with the father's parents. In July 2020, DCFS opened an intact family services case for the mother and indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect. The caseworker observed the mother had only one portable crib so provided two more and reminded the mother about safe sleep practices. The 2-year-old brother returned to his mother's care and a bed was provided for that child as well. In August 2020, DCFS indicated the brother's father in the March investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse. The caseworker had referred the mother for parenting classes, a mental health assessment was scheduled, and a day care application was being completed. Five days before the infant died, the caseworker emailed paperwork to the mother and attempted to call her, but the phone number was no longer in service.

Child No. 30	**DOB: 08/2020**	**DOD: 10/2020**	**Undetermined**
Age at death:	1 month		
Cause of death:	Undetermined		
Reason for review:	Split custody at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: One-month-old was found unresponsive face-down by his parents, who had placed him on a pillow, on his back, in the middle of an adult bed. The parents attempted CPR and called emergency services, who transported him to the hospital. The infant was resuscitated but suffered diffuse anoxic injury followed by multisystem organ failure. He was pronounced deceased the next day. The Department investigated the death and unfounded the investigation.

Prior History: In September 2017, the Department received a report that the infant's mother abused heroin in the past and had relapsed. The mother was investigated for substantial risk of physical injury/environment injurious to her then 1-year-old daughter; the investigation was unfounded due to appeal. An intact family services case was opened from February 2018 to August 2018 as a result of the report; the mother completed all recommended services. In August 2019, the parents were investigated after the Hotline received a report that the parents were found sleeping in a car at a gas station with their then 2-year-old daughter and gas station staff were unable to wake them. Police found cocaine, heroin, and drug paraphernalia in the car within the 2-year-old's reach. The family was brought to the emergency room and the father tested positive for cocaine. The 2-year-old came into care and was placed in relative care. In October 2019, DCFS indicated the parents for inadequate supervision, substantial risk of physical injury/environment injurious to health and welfare by neglect, and substance misuse by neglect. The infant was born while the placement case was open; his drug tests were negative. The parents were compliant with services including counseling, parenting classes, and substance abuse services and he was allowed to remain in his parents' care.

Child No. 31	**DOB: 10/2020**	**DOD: 12/2020**	**Undetermined**
Age at death:	6 weeks		
Cause of death:	Undetermined		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Six-week-old was found by her godmother unresponsive, face-up, in an adult bed, co-sleeping with the mother and 911 was called. Paramedics observed blood on the infant's clothing and blankets, as well as discharge coming from her nose and right ear. The infant had marks on her inner thigh and outside of her ankle, a mark on the bridge of her nose that appeared to be bleeding, and a healing scar on her left calf. The home was also observed to have empty alcohol containers. The infant was transported to the hospital and pronounced deceased. The Department investigated the infant's death and unfounded the

mother for death by abuse, as the cause of death was undetermined. The Department indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant's 19-month-old sister.
Prior History: In August 2019, the Department unfounded the parents for medical neglect to the infant's then 3-month-old sister after they failed to make an appointment for a blood test her pediatrician had requested. In January 2020, the Hotline received a report that the mother gave the infant's then 8-month-old sister melatonin, which had not been prescribed by a doctor. In February 2020, while the investigation was pending, the Hotline received a report that the mother had ongoing anger issues that placed the infant's sister at risk of harm, and that she would become intoxicated while caring for the infant's sister. The mother stated she and the father had separated, and the father came to her home, aggressively banged on her door around 11:30pm, and did not leave until she threatened to call police. She stated she only drank alcohol when out of the home, in social settings, not while caring for the sister. The mother denied giving the sister melatonin and stated she does not have trouble getting her to sleep. She stated she planned to obtain an order of protection against the father and had requested her landlord improve building security. The child protection investigator observed no marks or injuries on the sister and noted she was alert and happy, and a doctor who had recently seen the sister for a regular check-up reported the sister was healthy and well cared for. The Department unfounded both investigations.

Child No. 32	**DOB: 04/2019**	**DOD: 12/2020**	**Undetermined**
Age at death:	19 months		
Cause of death:	Undetermined		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nineteen-month-old found unresponsive by his mother and a neighbor called 911. The toddler was in cardiac arrest and was intubated. He died a month later, after being removed from a ventilator. He had been diagnosed the year before with Kawasaki disease, a rare disorder that causes inflammation of the blood vessels, but medical staff did not believe that caused his heart to stop. The autopsy was completed by a provider who specialized in pediatrics, and revealed no evidence of trauma, significant natural diseases, present or past broken bones, or asphyxiation. The Department opened an investigation into the death. The investigation is pending for death by neglect against the toddler's mother and father.

Prior History: In February 2020, the Hotline received a report that the then 9-month-old had bruises and circular burn marks on his torso and limbs, the parents sold illegal substances, and have a history of domestic violence. The child protection investigator met with law enforcement at the home. The child protection investigator did not observe any marks on the infant, and observed no safety concerns in the home. The parents denied any history of domestic violence, denied any history of substance use, and agreed to drug testing, which was positive only for THC. A nurse in the pediatrician's office noted they had seen the infant the month before and noted no concerns. The Department unfounded the investigation for burns by abuse; cuts, bruises, welts, abrasions, and oral injuries by abuse; and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 33	**DOB: 01/2020**	**DOD: 02/2021**	**Undetermined**
Age at death:	6 weeks		
Cause of death:	Sudden unexpected infant death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-week-old was found not breathing by his mother, who then called 911. The infant had fallen asleep on a nursing pillow. The Department opened an investigation into the death. The investigation is pending for death by neglect against the infant's mother.

Prior History: In July 2020, the Hotline received a report that the parents fought daily in front of the infant's then 3-year-old sister, and the fights often turned physical. The reporter added that the 3-year-old was struck during one fight. After interviewing the family and the 3-year-old's pediatrician, the investigation was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect because the mother did not live with the father and the 3-year-old and family members stated she had never been struck.

Child No. 34	DOB: 08/2020	DOD: 02/2021	Undetermined

Age at death:	6 months
Cause of death:	Undetermined
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death; one indicated and one unfounded child protection investigation within one year of child's death
Action taken:	Investigatory review of records

Narrative: Six-month-old was found unresponsive by his father, face-up, in an adult bed where he'd been laid down for a nap. Emergency services transported the infant to the hospital where he was pronounced deceased. The father was caring for the infant while the mother was at work. The Department investigated the infant's death and unfounded the father for death by neglect.

Prior History: In October 2020, the Hotline received a report that the father had been getting into fights near the family home, in the presence of the children. The mother stated she witnessed the father arguing with someone on the street, but the children were inside the home with her. The father stated some of his friends got into a physical altercation, but he did not get involved, and the children were not present. The Department unfounded the investigation. Six days after the previous investigation opened, the Hotline received a report that the mother had been pulled over by police. Reportedly, the mother smelled of alcohol, had bloodshot eyes, and admitted to drinking; the infant and his 1-year-old sibling were in the car, and the infant was not properly secured in his car seat. DCFS referred the family for intact family services and indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect. The intact worker documented a referral for beds for the children and the mother would be referred for counseling, parenting classes, drug testing, substance abuse counseling, and DUI evaluation. The family moved in with maternal relatives. Five days before the infant passed, the Hotline received a report that the infant's 3-year-old brother had a bruise near his eye and the infant's 5-year-old sister told the reporter their father hit him. The mother stated the father sometimes yells but did not hit the children, and the 5-year-old sister told the child protection investigator that her parents do not hit or spank them. She stated her brother hurt his eye when he fell while playing. The Department later unfounded the investigation.

Child No. 35	DOB: 12/2020	DOD: 03/2021	Undetermined

Age at death:	2 months
Cause of death:	Sudden unexpected infant death
Reason for review:	Closed intact family services case within one year of child's death
Action taken:	Investigatory review of records

Narrative: Two-month-old was found unresponsive by his mother approximately 45 minutes after she set him down to sleep in a battery-powered swing. The infant was transported to the hospital by ambulance where he was pronounced deceased. The Department unfounded its investigation of the infant's death and provided referrals for grief counseling.

Prior History: In 2016, mother was indicated for substantial risk of physical injury/environment injurious to health and welfare by abuse after she was charged with a DUI while the infant's then 4-year-old sister was in the car with her. In November 2016, the infant's then 21-month-old sister died while in

the care of the mother's paramour. The paramour was charged with first degree murder and was indicated for death by abuse and cuts, welts, bruises, abrasions, and oral injuries by abuse; the mother was a non-involved subject. In August 2019, mother was investigated and unfounded for substantial risk of physical injury/environment injurious to her newborn son. An intact family services case was subsequently opened from September 2019 to December 2020. The mother successfully completed services before the infant's birth, which included parenting classes, mental health therapy, and a drug and alcohol program.

Child No. 36	**DOB: 01/2021**	**DOD: 03/2021**	**Undetermined**
Age at death:	6 weeks		
Cause of death:	Undetermined		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-week-old was found not breathing by her mother. The day before, the infant and her twin brother were with paternal relatives when the infant began vomiting and gasping for breath. The paternal aunt called 911 and accompanied the infant to the hospital, while the paternal grandmother stayed home with the twin brother. At the hospital, she was diagnosed with congestion, and went home to her mother's house. The twin brother stayed with the father that night. Around 1:00am, the mother did not hear the infant's congested breathing and felt the home was cold. She took the infant from her crib, laid her on her back in a bunk bed and lay down with her. Approximately 30 minutes later, the mother awoke to find the infant was not breathing. The maternal grandmother started CPR while the mother called 911. The infant was pronounced deceased at the hospital. The infant's primary care and hospital physicians thought she might have died of a metabolic or genetic disorder, as her newborn blood tests were abnormal. The medical examiner's investigator found blankets and pillows on the bunk bed. The medical examiner could not rule out asphyxiation from co-sleeping. The Department unfounded its investigation of the infant's death.

Prior History: The infant lived with her mother, siblings, maternal grandmother, and a maternal aunt who had prior involvement. In June 2020, the Hotline received a report that the infant's maternal aunt threatened suicide in the presence of her children; took her children, who had asthma, out at inappropriate times; and one child had facial bruising. The maternal aunt told the investigator she had a history of domestic violence with her paramour. The 3-year-old cousin stated she had seen her parents fight and was afraid, but felt safe with her mother, the infant's maternal aunt. Multiple collateral contacts reported no concerns about the maternal aunt's mental health or her care for her children. At case closure, the 3-year-old cousin and other family members reported the maternal aunt's paramour had not been around recently. The maternal aunt stated she was going to obtain an order of protection. The investigation was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 37	**DOB: 12/2020**	**DOD: 03/2021**	**Undetermined**
Age at death:	3 months		
Cause of death:	Undetermined		
Reason for review:	Open intact family services case; pending child protection investigation at time of child's death; indicated child protection investigation within one year of the child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unresponsive, face down, by her 17-year-old mother. The infant had been co-sleeping with her mother in an adult bed with soft bedding and pillows while at the home of the infant's maternal great-grandfather. Emergency services took the infant to the hospital, where she was pronounced deceased. At the time of the infant's death there was a safety plan in place stating the mother was not to be alone with the infant and the maternal grandmother was the safety plan monitor. On the night of the infant's death, her mother took the infant from the grandmother's home to the maternal great-

grandfather's home in violation of the safety plan. The Department investigated the death and indicated the infant's mother for death by neglect.
Prior History: In August 2020, the infant's maternal grandmother gave birth and the baby tested positive for cocaine; this was the maternal grandmother's second substance-exposed newborn. The Department took protective custody of the mother and all her siblings, but the children were immediately returned home by the court under a supervision order and an intact family services case was opened. Service referrals included substance abuse counseling, drug testing, and parenting classes. The maternal grandmother gave guardianship of the newborn to a family friend. The Department indicated the maternal grandmother for substance misuse by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect. In December 2020, the teen mother gave birth to the infant, who tested positive for marijuana. The intact family services caseworker implemented the safety plan that the mother was to have only supervised contact with the infant until she completed three negative drug tests. There were multiple reported violations of the safety plan, and the intact family services supervisor reported repeated conversations with the court about bringing the children into care. In January 2021, the Hotline received a report that the infant's mother was involved in a fight while the infant was present at the maternal great-grandfather's home. The Department indicated the infant's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect. Four weeks before the infant died, the Hotline received a report that the mother was found in a hotel room with an adult and a gun, and the reporter was concerned she was being trafficked. The investigation remained pending at the time of the infant's death. In April 2021, DCFS indicated the maternal grandmother for inadequate supervision to the mother.

Child No. 38	**DOB: 12/2020**	**DOD: 04/2021**	**Undetermined**
Age at death:	4 months		
Cause of death:	Undetermined in the setting of co sleeping with two adults		
Reason for review:	Pending child protection investigation at the time of child's death		
Action taken:	Full investigation pending		
Narrative: Four-month-old found not breathing by her mother, who then called 911. Paramedics started CPR and transported the infant to the hospital, where she was pronounced deceased. The infant had been sleeping between her parents in their bed. The parents stated they were not aware of the dangers of co-sleeping. The Department investigated the infant's death and unfounded the parents for death by neglect.			
Prior History: In February 2021, the Hotline received a report that the mother had often been heard yelling at the infant's 9-year-old brother and threatened to punch him in the face during his Zoom classes. The 9-year-old told the child protection investigator he was not afraid of anyone in the home, and he did not remember his mother threatening to punch him. The 12-year-old stated her mother does yell but she did not recall her threatening anyone. The 15-year-old brother did not express concerns and the two-year-old was observed. The child protection investigator spoke to the mother who agreed to participate in intact family services. The February 2021 investigation was still pending at the time of the child's death. The Department later unfounded the investigation.			

Child No. 39	**DOB: 12/2020**	**DOD: 05/2021**	**Undetermined**
Age at death:	4 months		
Cause of death:	Sudden unexpected infant death; contributing factor of unsafe sleep environment		
Reason for review:	Youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		
Narrative: Four-month-old found unresponsive by his aunt who called 911. The infant was transported to the hospital where he was pronounced deceased. The aunt reported she and her paramour co-slept with			

the infant regularly, and his crib was observed to be filled with items. The caseworker involved with the family reported she had discussed safe sleep with the aunt and had observed a pack and play in the home. The Department indicated the aunt for death by neglect.
Prior History: In May 2017, the infant's siblings then ages 9 months, 23 months, 11 years, 14 years, and 15 years came into care and were placed with relatives. The mother was not participating in services and was not visiting with the children. The caseworker did not know that the mother was pregnant. In December 2020, the Hotline received a report that she gave birth to the infant and her other children had been removed from her care. The Department took the infant into care and placed him with his maternal aunt. In January 2021, the mother died due to complications of congestive heart failure. The investigation was pending at the time she died; the Department later indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. The infant's oldest sibling aged out of care and the next oldest sibling has a goal of independence. The other three siblings are in the process of being adopted by their grandmothers.

Child No. 40	**DOB: 10/2020**	**DOD: 05/2021**	**Undetermined**
Age at death:	6 months		
Cause of death:	Undetermined in the setting of co-sleeping		
Reason for review:	Return home within one year of the child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-month-old found not breathing while co-sleeping with his father and two-year-old sister. The father called 911. Upon arrival of emergency medical services, the infant was pronounced deceased. The father did not have appropriate sleeping arrangements for the infant or his sister. The father tested positive for opioids. The Department investigated the death and indicated the father for death by neglect.

Prior History: After an indicated report in November 2017, the Department took the infant's maternal siblings into care. The children remain in foster care as the mother and her husband have not completed all necessary services. In March 2019, the Department took the infant's then newborn sister into care. She was returned to their father's care in October 2019. In October 2020, the Hotline received a report that the infant and the mother tested positive for methamphetamines when the infant was born; the mother did not receive any prenatal care; and the mother was not to have unsupervised contact with the infant's then 19-month-old sister, but the infant's father allowed unsupervised contact. The Department took the infant into care placing him in a foster home. The Department indicated the mother for substance misuse by neglect. The Department unfounded the allegations against the father of inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect due to insufficient evidence. Ten days before the infant died, the court granted custody and guardianship of the infant to his father.

Child No. 41	**DOB: 03/2021**	**DOD: 05/2021**	**Undetermined**
Age at death:	2 months		
Cause of death:	Sudden unexplained infant death with unsafe sleep features		
Reason for review:	Two indicated child protection investigations and closed intact family services case within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Two-month-old found unresponsive by her parents and a relative. Paramedics transported the baby to the hospital, where she was pronounced deceased. The Department opened an investigation into the death and took the infant's 1-year-old brother into care. The investigation is pending for death by neglect against the infant's mother and father.

Prior History: In February 2020, after the mother gave birth to the older brother, DCFS opened an investigation on the 19-year-old mother who was indicated for sexual penetration of the 16-year-old father.

While the first investigation was pending the Hotline received a call stating the Mother had left the brother who was sick with a babysitter for days. The babysitter could not contact the mother and had to take the brother to the emergency room. The Department opened a high-risk intact family services case. In May 2020, while the high-risk intact case remained open, the Hotline received a report that the parents repeatedly left the now 3-month-old-brother unattended. The Department indicated the parents for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. In November 2020, while the mother was pregnant with the infant, the intact family services case closed unsuccessfully after the parents refused to participate in services and the court did not file a petition. In March 2021, the infant was born with high levels of THC in her system. The Department indicated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect. The investigator offered intact service which the parents refused. The infant died two months later.

Child No. 42	**DOB: 03/2021**	**DOD: 06/2021**	**Undetermined**
Age at death:	3 months		
Cause of death:	Undetermined		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old found not breathing, on an adult mattress with a plastic cover and no sheets, by her 3-year-old sibling who was co-sleeping with her. The 3-year-old woke the maternal grandmother, who was caring for the children at that time, while the mother was out. The grandmother called 911 and began CPR. The infant was transported to the hospital, where she was pronounced deceased. The Department opened an investigation and took protective custody of the infant's twin brother and 3-year-old sister. The children were returned to the mother's care who agreed to not allow the grandmother unsupervised contact while the death investigation was pending. The Department unfounded the grandmother for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Prior History: The infant lived with her mother, maternal grandmother, twin brother, and 3-year-old sister. Eight days before the infant died, the Hotline received a report that the infant's 3-year-old sister presented at the hospital for bug bites. Medical staff observed one hand was badly bruised and swollen, and she had multiple circular bruises. An investigation was opened for cuts, welts, and bruises to the 3-year-old by her mother. The child protection investigator attempted to see the child at the hospital, but she had been discharged. The treating physician reported no concerns, and stated the injury looked like a rash or allergic reaction, x-rays showed no injury, and the interactions between the child and mother were appropriate. The child protection investigator also made a good faith attempt to see the family at their home. The investigation was pending when the infant died. In August 2021, the Department unfounded the investigation.

ACCIDENT

Child No. 43	DOB: 02/2011	DOD: 07/2020	Accident
Age at death:	9 years		
Cause of death:	Multiple injuries due to motor vehicle striking pedestrian		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-year-old struck by a motor vehicle, while walking, resulting in multiple skull fractures. The Department did not investigate the child's death.

Prior History: The child lived with her mother, father, four maternal siblings, maternal grandmother, and maternal aunt. In February 2019, the Hotline received a report that the child's parents were neglectful and expected the child's then 9-year-old sibling to care for the child, then age 8, and her siblings, then ages 3, 4, and 6 years. The parents reportedly often screamed at the children and slapped the 9-year-old, the children often appeared dirty and smelled and the mother was alleged to be using substances. The reporter shared that the children often slept on the floor and there was frequent domestic violence between the parents. The father had previously been incarcerated. The child protection investigator observed the home to be safe, with adequate sleeping arrangements, and the parents denied all allegations. The grandmother denied witnessing any physical altercations between the parents and stated the children were well cared for. The children reported feeling safe at home. Neither parent had a record of convictions. In November 2019, the Department unfounded the investigation.

Child No. 44	DOB: 03/2018	DOD: 07/2020	Accident
Age at death:	2 years		
Cause of death:	Blunt trauma of head due to pedestrian vs motor vehicle		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old ran into the street and was hit by a box truck while the parents were getting ready to leave the home and putting the toddler's sister in the car. The father immediately drove her to the hospital, about one mile from the home. She was pronounced deceased upon arrival. The Department investigated the death and indicated both parents for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Prior History: In March 2020, the Department investigated the parents for substantial risk of physical injury/environment injurious to health and welfare to their two children following a report of domestic violence incident between the parents resulting in the father's arrest for domestic violence as well as possession of marijuana. The children, then ages 23 months and 3 years, were present but reportedly not physically harmed. Police had responded to prior domestic violence reports at the home. The investigator met with the father upon his release on bail. The father was living with the children at his brother's home and the mother was staying with a friend. The investigator completed substance abuse and domestic violence screenings; observed the children, who were free of marks and bruises; and assessed the children as safe. The father's bail conditions stated he was not to have contact with the mother. The investigator spoke with the mother by phone, who reported she was ending the relationship, but would not file an order of protection. The mother reported she had contacted a community resource for services, but group sessions were canceled due to the COVID-19 pandemic. In May 2020, the investigator went to the home and observed the children. The father reported he and the mother communicated only through friends and family so she could see the children. The Department unfounded the investigation against the mother and indicated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect due to the domestic violence incident.

Child No. 45	DOB: 12/2017	DOD: 08/2020	Accident
Age at death:	2 years		
Cause of death:	Asphyxia due to suffocation		
Reason for review:	Two pending child protection investigations at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old medically complex child was found in his crib, not breathing. The mother reported being awakened by medical equipment alarms, clearing his tracheostomy tube, starting CPR, and calling an ambulance. Upon arrival EMTs took over CPR and transported the toddler to the hospital, where he was pronounced deceased. The toddler had been diagnosed with Cornelia DeLange syndrome at birth, a genetic disorder affecting neurology tone and causes seizures, feeding issues, and mental and physical delays. He also had a congenital heart defect that had been corrected through surgery, subgalottic stenosis, and adrenal insufficiency. The toddler required a feeding tube, tracheotomy tube, and supplemental oxygen. He also required frequent suctioning of his tracheotomy tube and airway and had at least three prior episodes of mucus plugging his airway resulting in respiratory failure, requiring CPR. He received in-home nursing care through the Division of Specialized Care for Children. The Department indicated the mother for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Prior History: In June 2020, hospital staff reported to the hotline that the mother was not bringing the toddler to necessary appointments having missed four appointments in the previous two months. The reporter added that the mother often slept while the toddler's in-home nurse was caring for him, leaving the toddler's 11-month-old brother unsupervised. The mother denied that the in-home nurse cared for the brother, and the nurse said she did things for the brother by choice. The mother stated she missed appointments due to transportation issues. She said she did not use medical transport as the toddler's infant brother was not allowed, and because she was concerned about the toddler's compromised health during the COVID-19 pandemic. She added that telehealth appointments were missed because of phone problems. She said the toddler had also been in the hospital in April 2020. The mother initially accepted intact family services. In July 2020, the toddler was admitted to the hospital for cardiac arrest but was revived. In August 2020, while the initial investigation was pending, the hotline received a report that the toddler's tracheotomy collar was dirty and did not have the heat and moisture exchanger ("HME") on to keep moisture in the tracheotomy tube, and the reporter had seen the toddler without the HME in place on multiple occasions. The reporter stated the missing HME put the toddler at risk of mucus plugging his tracheotomy tube, which could result in respiratory failure or cardiac arrest. Upon discharge, the mother was asked to arrange for a high-humidity collar for him to wear at night. The mother did not call until after the second hotline report was made, 10 days after discharge. The nurse who visited the home to fit the collar observed fifteen boxes of unopened medical supplies which there should not have been if the mother was using them as prescribed. The mother explained that the supplies had just been delivered that week and she still had supplies from a previous shipment. The mother also reported she had called to have the HME repaired but had not heard back. The medical equipment manager stated they had not received a call. The investigator assessed the toddler and his brother as safe with the plan to make a nursing referral. The mother agreed to intact family services. The investigator spoke with a nurse in the pediatrician's office who told the investigator she had guided the mother on cleaning the toddler's tracheotomy tube and had no concerns about neglect. Three days later, less than two weeks after the most recent investigation was opened, the toddler died. The Department indicated the mother for medical neglect in both investigations after the toddler died.

Child No. 46	DOB: 06/2020	DOD: 08/2020	Accident
Age at death:	2 months		
Cause of death:	Sudden unexpected infant death with co-sleeping		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was found unresponsive by his mother. The mother reported she fed the infant and his twin sister around 6:00am, and placed them on either side of her in bed. The twin sister awoke around 9:30am, at which point she found the infant unresponsive. 911 was called, but his father and paternal grandmother took the infant to the hospital before the ambulance arrived. The infant was pronounced deceased upon his arrival at the hospital. The mother tested positive for marijuana and a substance thought to be Suboxone. The Department investigated the infant's death and indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to the twins. The mother was also indicated for burns by neglect, as both twins were observed to have small burns, but it is unclear how they received them. The parents were unfounded for the infant's death.

Prior History: The mother has a history with the Department relating to the infant's maternal brother. Between his birth in 2011 and 2017, the mother was indicated six times for allegations including inadequate supervision, substantial risk of physical injury/environment injurious to health and welfare by neglect, and each of the indicated allegations related to the mother's substance abuse. In 2012, she gave guardianship of the brother to a relative out of state, but the mother was allowed unsupervised visits. In February 2017, DCFS opened an intact family services case and the mother sought inpatient substance abuse treatment. In July 2017, the mother signed over guardianship of the brother to her paramour at the time, and DCFS closed the intact case. The brother still resides with the paramour, who is no longer involved with the mother. Three weeks before the infant's death, the Hotline received a report that the mother gave birth to the infant and his twin sister the month before and the parents were using substances while the twins were in their care. In addition, the mother was intermittently nursing the twins. The father denied substance abuse and the mother told the child protection investigator that she had been clean since completing a substance treatment program in 2017. The child protection investigator did not observe drug paraphernalia in the home and noted the parents did not appear to be intoxicated. The paternal grandmother agreed to stay in the home to supervise the parents with the twins until the parents completed drug tests. At the initial test, the mother tested positive for marijuana and the father tested negative; the mother was asked to complete a substance abuse evaluation. The investigation was pending when the infant died but was indicated after the death.

Child No. 47	DOB: 11/2005	DOD: 09/2020	Accident
Age at death:	14 years		
Cause of death:	Blunt force chest trauma		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old was riding as a passenger in a car when the car began to fishtail and rolled over. The teenager was pronounced deceased at the scene. The 15-year-old driver of the car and the driver's younger sibling, who was also a passenger in the car, survived with injuries. The teenager lived with her mother and stepfather but was in the care of the parents of the driver at the time of her death, as she was spending the weekend at their home. The Department investigated and indicated the driver's mother for death by neglect; bone fractures by neglect; cuts, welts, bruises, and oral abrasions by neglect; and substantial risk of physical injury by neglect.

Prior History: In October 2019, the Department opened an investigation following a report that the teenager's 23-year-old sister left her 2-year-old daughter with an alternate caregiver but did not provide dates and times she would return for her daughter. The investigation was unfounded for

abandonment/desertion due to insufficient evidence to support the allegation. Three days before the teenager's death, the Department opened an investigation against the teenager's sister after receiving a report that when the teenager stayed at her sister's home, she would share the couch with a 21-year-old family friend, and a sexual relationship was suspected. The teenager died in the car accident before her interview at the Children's Advocacy Center could be held. The investigation was later unfounded because the teenager's mother, sister, and the 21-year-old all denied there was an inappropriate relationship between the teenager and the 21-year-old.

Child No. 48	**DOB: 09/2018**	**DOD: 09/2020**	**Accident**
Age at death:	23 months		
Cause of death:	Drowning		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-three-month-old was found unresponsive in the pool where the family was temporarily residing at approximately 9:45am. The mother woke up and could not find the toddler, who was normally loud when he woke up. She saw the door was open and immediately went outside, where she found him at the edge of the pool, with purple lips. The mother and her paramour's grandmother called 911. The toddler was transported to the hospital by EMS, where he was pronounced deceased. The Department unfounded the investigation into the toddler's death.

Prior History: In July 2019, the Hotline received a report the mother slammed the then 10-month-old toddler's head into a door; the toddler had a big bruise from the incident; the home was cluttered with clothing and trash; and a member of the household was using illegal drugs and often passed out from drug use. The investigator found the home was cluttered but there was no trash, and the household member had a history of drug use but was compliant with daily methadone treatment. The investigator observed a bruise on the toddler's forehead but no other marks. The mother and other household members reported he hit his head on a door, but it was an accident, as she did not realize the toddler was behind the door when she opened it. The mother denied using physical discipline. The investigation was unfounded. The mother agreed to participate with intact family services as she reported having mental health issues and was not taking any medication due to a new pregnancy. The mother also requested housing assistance. The mother admitted to the caseworker that she had used illegal drugs in the past but had been clean for three months. She completed a mental health screening but did not complete a substance abuse screening as she felt the latter was not needed. The family received housing assistance and moved into a new home and provided a toddler bed. The toddler's younger sister was born in May 2020. The intact family services case was closed approximately four months prior to the toddler's death.

Child No. 49	**DOB: 06/2020**	**DOD: 10/2020**	**Accident**
Age at death:	16 years		
Cause of death:	Skull fractures with intracranial hemorrhage due to blunt force trauma of head due to fall down stairs at home		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old was found on the garage floor with a head injury. The teen was transported by ambulance to the hospital and admitted with a head bleed. He was pronounced deceased six days later. The Department investigated and unfounded the teen's death.

Prior History: In September 2019, the Hotline received a report that the teen was using and selling marijuana in the family home, and after discovering the teen and his friends drinking in the garage, the mother allowed them to continue and did nothing to stop them. The mother was investigated and unfounded for substance misuse by neglect and inadequate supervision and substantial risk of physical

injury/environment injurious to health and welfare by neglect. The mother, the teen, and the teen's 7-year-old sister moved out of the family home and into the home of maternal grandmother. The teen stated he began smoking marijuana when his father was murdered but said he recently stopped. The teen denied selling drugs and denied using any substances other than marijuana. He told the investigator that his mother was aware that he smoked marijuana and tried to get him help. The mother and grandmother confirmed that they previously tried to get the teen help and were currently trying to get him into a treatment program. The grandmother reported the family was staying with her temporarily while the mother looked for her own place. The grandmother said she did not allow the teen to use marijuana in her home, she searched him when he came into the home, and had not found evidence of drugs. In October 2019, the investigation was unfounded.

Child No. 50	**DOB: 11/2002**	**DOD: 10/2020**	**Accident**
Age at death:	17 years		
Cause of death:	Motor vehicle accident		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		
<u>Narrative</u>: Seventeen-year-old was pronounced deceased at the hospital after a motor vehicle accident when she was driving. The teen was pregnant at the time of her death. The Department did not investigate her death.			
<u>Prior History</u>: In 2012, following multiple indicated reports, the teen became a youth in care and was placed in a traditional foster home. In 2017, the teen was adopted by her foster parent. In June 2020, the Hotline received a report that the teen stated her adoptive father touched her vagina two or three years prior and was emotionally abusive. During the investigation, the teen refused to speak with child protection investigators and did not provide any further details. A previous foster sibling reported no concerns with the adoptive father. In July 2020, while the June 2020 investigation was pending, the Hotline received a report that the teen's adoptive brothers were fighting, and the adoptive father allowed it. The brothers denied the allegation. Both investigations were unfounded.			

Child No. 51	**DOB: 06/2020**	**DOD: 10/2020**	**Accident**
Age at death:	3 months		
Cause of death:	Asphyxia due to prone sleeping position due to co-sleeping in an adult bed with multiple persons		
Reason for review:	Open intact family services case at time of child's death; one indicated and one unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		
<u>Narrative</u>: Three-month-old was found unresponsive by her mother at approximately 3:00am. EMS was called, and the infant was transported to the hospital by ambulance, where she was pronounced deceased. Both parents admitted drinking and smoking marijuana and then co-sleeping with the infant. The Department investigated the infant's death and indicated the parents for death by neglect.			
<u>Prior History</u>: In August 2019, the Department opened an investigation following a Hotline report that the infant's then 5-year-old brother said his father hit him in the nose hard enough to make his nose bleed. During the investigation the 5-year-old gave various time frames. The child also reported that his father hit his mother. The child protection investigator observed the 5-year-old and his sibling noting no signs of abuse or neglect. The parents denied abuse and domestic violence; and local law enforcement had no records of contact for domestic violence. The investigation was unfounded for substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect. In March 2020, the Department opened an investigation following a report the infant's 5-year-old brother arrived at school with a scratch on his face. The 5-year-old said that his father choked and punched his mother, who was			

pregnant, and he received the injury when he tried to help his mother. The 5-year-old added that his father also broke down the bathroom door, injuring the 5-year-old. The child protection investigator observed a scratch to the child's upper lip. His mother and sibling denied witnessing an incident between the father and child. The father denied causing injuries to the child. Police arrested the father for domestic battery after he admitted to pushing and choking the mother while the children were present. The Department indicated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect and opened a high-risk intact family services case. Recommended services included domestic violence and individual counseling. The father was also court ordered to complete anger management. The mother was referred for and started counseling. The father completed a domestic violence assessment that recommended 26 weeks and was waiting for his sessions to start. In September 2020, the intact worker documented discussing safe sleep with the mother after the mother disclosed co-sleeping with the infant. The intact case remained open at the time of the death.

Child No. 52	**DOB: 01/2020**	**DOD: 10/2020**	**Accident**

Age at death:	8 months
Cause of death:	Positional asphyxia due to prone sleeping on adult mattress with swaddling and blanket; significant contributing factor of viral upper respiratory tract infection
Reason for review:	Open high-risk intact case at time of child's death; indicated child protection investigation within one year of child's death
Action taken:	Investigatory review of records

Narrative: Eight-month-old was found unresponsive and not breathing. He was displaying signs of having a cold, and was given infant cold medicine, then placed down for a nap, face-down, in a swaddle, on an adult bed. The infant's godmother was caring for him at the time. She checked on him multiple times during the nap. Approximately four hours after he went down, she saw he was purple and had vomit around his head. She called 911 and administered CPR until emergency responders arrived. The infant was transported to the hospital, where he was pronounced deceased. The Department investigated the death and indicated the infant's godmother for death by neglect, environmental neglect, and inadequate supervision – left alone at home or in the community.

Prior History: In August 2020, the Department investigated the mother following a report that she brought the infant's 5-year-old brother to the emergency room when he was in respiratory distress, then became agitated and left the hospital. The infant's godmother came to the hospital when they called the contact number they had on file for him, but she was unable to consent to any medical treatment. The mother did not answer the phone when the hospital called her, and they were unable to obtain her consent for treatments, delaying needed care. The mother explained she was pregnant, her pregnancy was considered high-risk, she was concerned about COVID-19, misunderstood that the 5-year-old had not yet been admitted, and she thought she had provided the necessary consents. The Department indicated the mother for inadequate supervision and medical neglect with the rationale that although she brought the 5-year-old in for treatment, she left the hospital before the infant's godmother arrived and before giving medical consent. The Department opened a High-Risk Intact Family Services case that included services for parenting classes, counseling, and setting up protective daycare for the infant and his siblings while the mother worked.

Child No. 53	DOB: 04/2020	DOD: 11/2020	Accident
Age at death:	7 months		
Cause of death:	Asphyxia due to prone sleeping in an adult bed due to co-sleeping with adults		
Reason for review:	Two pending child protection investigations at time of child's death; closed intact family services case within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Seven-month-old was found unresponsive by her 6-year-old brother. The parents initially reported the infant was sleeping in a pack and play DCFS had provided the day before, but the parents later admitted the infant was sleeping in an adult bed with her brother. The father tested positive for methamphetamine and the mother positive for benzodiazepines for which she did not have a prescription. Three of the infant's four siblings, ages 1 to 6, were observed to have injuries including small bruises, scratches, bite marks, and head bumps. The Department investigated the infant's death and indicated the parents for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Prior History: In 2019, the Department indicated the parents for failure to thrive to the then newborn brother. Between April 2019 and May 2020, the parents had an open intact family case with DCFS. At case closure, the worker noted the parents had completed all recommended services. In August 2020, the Hotline received a report of ongoing domestic violence in the home, in front of the children, and possible substance abuse issues. The parents denied the allegations and the child protection investigator observed no outward signs of abuse or neglect to the children. The 6-year-old denied witnessing any fighting and reported feeling safe in the home. The parents agreed to drug testing; the mother tested positive for methamphetamines and the father failed to complete his drug test. In September 2020, while the previous investigation was pending, the Hotline received a report that the father punched the mother and she sustained a black eye. The on-call child protection investigator observed the children and documented no suspicious marks or bruises. The mother stated the father had forced her to use methamphetamines as recently as a few days prior, and reported she was willing to comply with intact family services and obtain an emergency order of protection against the father. The children were assessed as unsafe and the mother agreed for her and the children to stay with an aunt. The investigation was pending at the time the infant died. In February 2021, the Department indicated the infant's mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 54	DOB: 05/2000	DOD: 11/2020	Accident
Age at death:	20 years		
Cause of death:	Multiple injuries due to motor vehicle striking fixed object		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Twenty-year-old was a passenger in a vehicle that was driving at a high rate of speed when the driver lost control of the vehicle and crashed into a tree. The youth was declared dead at the scene. He had last been seen that morning by staff at his transitional living program. The Department did not investigate his death.

Prior History: In 2014, the then 14-year-old youth, his 8-year-old brother, and his newborn sister came into care after the newborn sister tested positive for cocaine at birth. The youth moved between relative placement, juvenile detention, foster care, and residential placement. In 2018, he moved to a transitional living program, though had some periods of elopement and detention. Between June 2020 and his death in November 2020, he remained at the transitional living program. He worked with his case manager on services towards independence and hoped to move in with his grandmother and siblings once his case closed.

Child No. 55	DOB: 08/2020	DOD: 11/2020	Accident
Age at death:	3 months		
Cause of death:	Craniocerebral blunt trauma		
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death; four unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was in a car accident with his parents and three older siblings, while his father was driving. He, his mother, and his 21-month-old sibling were taken to the hospital by ambulance, and the children were transferred to a children's hospital. He had a depressed skull fracture and was pronounced deceased the next day. His mother also died as a result of the accident. The 21-month-old sibling sustained a head injury but was treated and later discharged from the hospital. The infant's 2-year-old and 4-year-old siblings had sustained only bruises and scratches and were treated in the ER. Law enforcement determined the infant was not properly restrained and the father was driving at a high rate of speed in excess of 25 mph over the speed limit. The Department investigated the death and indicated the father for death by neglect, head injuries by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Prior History: Between October 2019 and November 2020, the Department initiated five investigations, which overlapped. Four were unfounded; the fifth was pending at the time of death and later indicated. The family was living with the paternal grandparents. In October 2019, the Hotline received a report that the infant's then 22-month-old sibling presented at the pediatrician's office with an old burn on the wrist that was blistered and dirty. The father reported the child touched a burn barrel that was heating the paternal grandfather's garage a few days earlier. The parents treated the burn at home for a few days, but when it did not appear to be healing, they took the child to the pediatrician. The child protection investigator observed the burn, noting that it was healing, and the wound had closed. The pediatrician confirmed the parents brought the toddler for a follow-up appointment and observed the wound was healing. The doctor's office noted the paternal grandmother was their only source of transportation, so they sometimes missed appointments for the children. The Department unfounded the investigation for burns by abuse and environmental neglect, but the family agreed to intact family services. In November 2019, while the previous investigation was still pending, the Hotline received a report that the infant's then 9-month-old sibling was transported to the hospital for failure to thrive; the infant's then 23-month-old sibling was also not gaining weight, and both children had recently missed appointments for weight checks. During the hospitalization it was discovered that the 9-month-old suffered from a food allergy causing the failure to thrive. The parents were enrolled in WIC and medical specialist appointments were made for the children. In December 2019, the mother disclosed that she recently learned she was pregnant with the infant, her fourth child. The Department unfounded the investigation. That same month the Hotline received a report that the mother brought the infant's then 2-year-old sibling to the ER because of mucus and blood coming from the ears, congestion, cough, fever and the children were dirty and small for their ages. The parents reported they bathed the children daily, and the home was observed to have adequate food. The paternal grandmother confirmed that the parents feed and bathe the children but do get overwhelmed. The father reported they brought the child to the hospital because he feared one of the child's tubes had fallen out of his ear as there was so much drainage. The Department unfounded the investigation and an intact case was opened. The family was recommended housing services, parenting classes, and nursing services. In August 2020, the infant was born, and the mother was concerned about failure to thrive due to the issues her other children had experienced; she reported she planned to nurse and use formula to prevent that from happening. The family met with the intact worker outdoors, but they denied him access to the home, citing COVID-19 concerns. The infant's pediatrician informed the intact worker that the family had attended all appointments, though they were all telemedicine appointments due to the pandemic. In October 2020, the Hotline received a report that the mother and three of the four children were staying with a registered sex offender. The child protection investigator observed the

children in their father's home. The parents reported they got into an argument and the mother left with three of the children but denied taking them to the home of the person in the report. The investigation was pending at the time of the infant's death but was later unfounded. One week after the previous investigation, the Hotline received a report that the then 1-month-old infant was seen at his pediatrician's office, and immediately sent to the ER. At the hospital, a physician thought it would be best for him to be taken to the children's hospital as he was tachycardiac, and dehydrated, but an ambulance would not be available for transport for a few hours. Instead of waiting at the hospital, the mother left with the infant to get something to eat despite medical staff's advice to have someone bring her food. The mother later returned with the infant to wait for the ambulance. The father told the investigator that while he was on the phone with the mother, he overheard a nurse say she could leave to get food as long as they were back by 9:00pm for the ambulance. At the hospital the infant was switched to a new formula, he began gaining weight, and he continued to gain weight after release. The parents reported they would continue to cooperate with intact family services. The investigation remained pending at the time of the infant's death. In December 2020, the Department indicated the investigation for medical neglect and failure to thrive.

Child No. 56	**DOB: 04/2019**	**DOD: 12/2020**	**Accident**
Child No. 57	**DOB: 09/2017**	**DOD: 12/2020**	
Age at death:	20 months; 3 years		
Cause of death:	Asphyxiation due to smoke inhalation due to residential fire		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-month-old, three-year-old, and their father died in a house fire. The mother was at work when the fire occurred, and their 8-year-old sister was at school. The Fire Marshall was unable to determine the cause of the fire, but reported no foul play was suspected. Surviving family members stated they had issues with the furnace in the past, but the landlord had not addressed them. The Department investigated the death and unfounded the parents for death by abuse.

Prior History: In December 2019, the Hotline received a report that the children's father sexually abused the children's 14-year-old cousin on multiple occasions. The cousin had disclosed the abuse to a counselor, and confirmed the disclosure to the child protection investigator, but declined to participate in a forensic interview, stating she did not wish to discuss the incidents further. Collateral contacts also believed the abuse occurred. The Department indicated the investigation for sexual molestation.

Child No. 58	**DOB: 06/2005**	**DOD: 12/2020**	**Accident**
Age at death:	15 years		
Cause of death:	Multiple injuries due to motor vehicle striking semi-truck		
Reason for review:	Three unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old was a passenger in a car that hit a semi-truck at high speed. The teenager was taken to the hospital with severe head trauma. She was pronounced deceased three days later. The Department did not investigate the death.

Prior History: The family had been involved in five child protection investigations prior to her death. In June 2019, the Hotline received a report that the teenager's then 12-year-old brother was skipping school and busking on a street corner. The children were living with their maternal grandmother at the time. The Department unfounded the investigation for inadequate supervision. In July 2019, the Hotline received a report that the teenager and her then 12-year-old brother were hungry all the time because their mother bought drugs instead of food and gave drugs to the teenager, the home was unsanitary, and the children wore dirty clothes. The investigation was unfounded for inadequate food, substance misuse, and environmental neglect. In November 2019, the Hotline received a report that the teenager's parents were

using marijuana and alcohol with the teenager and her then 12-year-old and 16-year-old brothers. In January 2020, the investigation was unfounded. In February 2020, the Hotline received another report that the teenager's parents were using marijuana and there was no food in the home. The investigation was unfounded for inadequate food as the Department was unable to locate the family and the prior investigation had similar allegations. In November 2020, the Hotline received a report from a neighboring state's child welfare agency that the teenager's 13-year-old brother, along with an 8-year-old and a 14-year-old, were found with another individual driving in a stolen vehicle that contained guns and marijuana. The driver was arrested but the three passengers were released to their parents after being seen at the hospital. The 13-year-old was staying with his uncle that weekend but left the home without permission. The investigation was unfounded because the parents created a care plan for the 13-year-old to stay with his uncle for the weekend.

Child No. 59	**DOB: 04/2014**	**DOD: 01/2021**	**Accident**
Age at death:	6 years		
Cause of death:	Inhalation and thermal injuries due to inhalation of smoke and soot due to a house fire		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-year-old died in a house fire. The deceased was at home with four siblings, ranging in age from 1 year to 13 years, with no adult supervision. After smelling smoke, four of the children went to a neighbor's house. Upon realizing the 6-year-old was not with them, they attempted to go back, but were unable to because of heavy smoke. The neighbor called 911, and responding fire fighters found the child on top of a bunkbed, in an upstairs bedroom. He was transported by ambulance to the hospital, where he was pronounced deceased. The Department investigated the death and indicated an adult cousin for death by neglect and inadequate supervision. The cousin admitted he was in a caretaker role at the time of the fire and left the children alone. The Department unfounded the mother for all allegations as she had left the children in the care of the cousin.

Prior History: In March 2020, the mother was investigated for inadequate supervision following a Hotline report that her 12-year-old had not been to school since September and it was believed he was made to stay home to watch his younger siblings. The mother denied the allegations and said she stayed home with her children. She told the investigator that the 12-year-old was not in school because he was having problems with teachers and students and requested assistance with getting him into a new school. The 12-year-old denied being left alone with his younger siblings. A collateral contact stated the mother would never leave her children alone and had called her when she needed someone to babysit. The child protection investigator made two unannounced visits and found the mother home with the children. The mother reported she made the 12-year-old attend school after the Department opened the investigation. The investigation was unfounded.

Child No. 60	**DOB: 09/2020**	**DOD: 01/2021**	**Accident**
Age at death:	3 months		
Cause of death:	Asphyxia due to unsafe sleeping environment		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unresponsive and cold to the touch around 6:00am. The infant's mother stated she fed the infant around 3:00am, then placed the infant on a nursing pillow and went to sleep. The mother called 911; paramedics attempted CPR and transported the infant to the hospital, where she was pronounced deceased. The mother admitted to drinking alcohol that night. The Department investigated the death and indicated the mother for substantial risk of physical injury/environment

injurious to health and welfare by neglect due to unsafe sleeping practices. The Department unfounded its allegation of death by neglect.
Prior History: Between 2017 and 2018, the family was involved in four child protection investigations; two investigations were indicated, and one was unfounded on appeal. The indicated allegations included inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. In June 2020, the Hotline received a report that the mother, who was five months pregnant with the infant, was drinking, using drugs, and was going to be evicted from the home she lived in. The infant's then 3-year-old brother and 8-year-old sister lived with their fathers at the time. The mother completed a drug test which was negative for all substances except marijuana, and she had a medical marijuana card. The investigation was unfounded.

Child No. 61	**DOB: 11/2020**	**DOD:02/2021**	**Accident**
Age at death:	3 months		
Cause of death:	Asphyxia due to unsafe sleeping environment		
Reason for review:	Return home within one year of child's death; one indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		
Narrative: Three-month-old was found unresponsive, face down, between her mother and the back of the couch. Her mother had fallen asleep with her on the couch. The Department investigated the death and unfounded the mother for death by neglect.			
Prior History: In April 2020, the Hotline received a report that the parents had created fraudulent online dating profiles, lured a person to their apartment, and robbed him at gunpoint while the infant's then 18-month-old sister was home. Both parents were arrested. The father was incarcerated, and the mother was placed on home confinement with a family member. The Department took the sister into care placing her with her maternal grandmother. The Department indicated both parents for substantial risk of physical injury/environment injurious to health and welfare by neglect. The mother completed parenting classes, was actively engaged in services, and had unsupervised overnight visits with the infant's sister. In November 2020, the Department opened another investigation due to the infant's birth, though the infant remained in the mother's care because the she was cooperating with her services, and the investigation was unfounded. In December 2020, the court returned custody of her sister to their mother, and the Department retained guardianship.			

Child No. 62	**DOB: 03/2020**	**DOD: 03/2018**	**Accident**
Age at death:	12 months		
Cause of death:	Dog bite wound of the head		
Reason for review:	Two indicated child protection investigations within one year of child's death		
Action taken:	Full investigation pending		
Narrative: Twelve-month-old was attacked in the face by the family dog while reaching into the dog's food bowl. The infant was taken to the hospital by ambulance and was pronounced deceased at the hospital. The infant's maternal grandmother stated the dog had once nipped another child on the bottom when they were wrestling, but the dog had never been aggressive and was not known to be aggressive around its food. The Department opened an investigation into the death. The investigation is pending for death by neglect against the infant's mother and grandmother.			
Prior History: At the time of her death, the infant was living with her mother, maternal grandmother, grandmother's paramour, and two maternal uncles. In 2019, the Department unfounded the mother in one investigation, and unfounded the infant's maternal grandmother in one investigation. In March 2020, the Hotline received a report that the infant and the mother both tested positive for cocaine at the infant's birth, and the mother admitted to using cocaine. The mother initially retained custody of the infant with			

an agreement that the infant's maternal grandmother, who had her own history with the Department, would obtain custody if she was not compliant. Less than two weeks later, the mother left the home and the child protection investigator provided the maternal grandmother with guardianship paperwork. In August 2020, the infant's maternal grandmother petitioned to obtain guardianship of the infant, but all parties failed to appear in court. In November 2020, the Hotline received a report that the infant's 6-year-old maternal brother was kicked in the face by the infant's 15-year-old maternal uncle in the family home, and the 6-year-old required medical attention. The maternal grandmother consented to allowing the 6-year-old to reside permanently with his father. The maternal uncle admitted that he became frustrated with the 6-year-old and shoved him off his lap, and understood that his behaviors were inappropriate. In January 2021, the Department indicated the investigation for cuts, welts, bruises, and oral abrasions by abuse.

Child No. 63	**DOB: 05/2003**	**DOD:03/2021**	**Accident**
Age at death:	17 years		
Cause of death:	Methamphetamine and fentanyl intoxication		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old overdosed on methamphetamine and fentanyl at an unrelated adult's home, where he had been living intermittently. Someone in the home administered Narcan and the teenager was laid on a couch. A few hours later, he was seen bleeding from the mouth and 911 was called. The teenager was pronounced deceased when paramedics arrived at the scene. The Department investigated his death and indicated the unrelated adult that the teenager was living with for death by neglect. The Department also investigated and unfounded the teenager's mother.

Prior History: In July 2020, the Hotline received a report that the teenager's then 13-year-old brother returned home from a visit with his mother and reported she was using methamphetamine. The teenager still lived with his mother though his brother did not because of the mother's unstable housing. The teenager, his brother, and their mother all denied any methamphetamine use. The teenager admitted to using marijuana and stated he had sold drugs in the past but had stopped after he got in legal trouble. Local law enforcement reported the mother had no recent police activity and did not have any drug charges on her record. The Department unfounded the investigation.

Child No. 64	**DOB: 10/2019**	**DOD: 05/2021**	**Accident**
Age at death:	18 months		
Cause of death:	Ligature strangulation		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eighteen-month-old was found in her bedroom with the cord from her window blinds wrapped around her neck. The mother called 911 and CPR was administered. Paramedics transported the toddler to the hospital, where she was pronounced deceased. The Department investigated the child's death and indicated the mother for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect to the toddler's 2-year-old brother. The Department unfounded the toddler's father.

Prior History: In March 2019, the Department indicated the father for burns by neglect to the infant's then 3-month-old brother. In January 2020, the Department indicated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect to the then 2-month-old infant and her then 14-month-old brother. In April 2020 the Department opened an intact family services case, with recommendations for individual counseling and domestic violence counseling. Due to the COVID-19 pandemic, the assigned worker maintained weekly phone and video visits with the family and met with

them in-person once per month. In February 2021, the Department closed the intact family services case because the family's service goal was achieved.

Child No. 65	**DOB: 05/2004**	**DOD: 05/2021**	**Accident**
Age at death:	17 years		
Cause of death:	Polysubstance toxicity (methamphetamine, MDMA, fentanyl) due to polysubstance abuse		
Reason for review:	Youth in care; one indicated and two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was found unresponsive by his cousin, whose house he had stayed at the night before. The cousin left for work at approximately 6:00am and saw the teen sleeping on the couch. When she returned home around noon, she noticed he was still asleep and found he was cold to the touch. She called 911 and began CPR. Paramedics were unable to revive the teen. The cousin denied knowing the teen had drugs with him when he came to her residence but stated he had been known to use methamphetamine, heroin, and pills. The Department did not conduct an investigation of the teen's death.

Prior History: In February 2020, the Department opened an investigation of the teen's aunt after the then 15-year-old teen was admitted to the hospital and tested positive for cocaine, opiates, benzodiazepines, and cannabis. The Department indicated her for medical neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect. In March 2020, the Department took the teen into care because he did not have a legal guardian and his aunt no longer wanted the teen in her home. In May 2020, the Hotline received a report that the teen's paternal sister used cocaine and ecstasy with the then 16-year-old teen and was under the influence in the presence of her children. The Department unfounded the investigation as the reports of witnesses were inconsistent, and the paternal sister tested negative for illegal substances. In June 2020, the Hotline received a report that the mother was using methamphetamine daily, sometimes with the teen, and was also intoxicated when her 2-year-old grandson was in her care. The report alleged the mother was not to be around any minors. The teen's maternal sister stated the mother did not use methamphetamine, and she did sometimes leave her son with the mother for a few hours at a time. The teen stated he had not seen his mother in several months and did not use drugs with her. At that time, the teen was placed with a man who was later found to be the paramour of the teen's mother, and the teen lived with his mother and the paramour. The Department indicated the mother for substance misuse by abuse and substantial risk of physical injury/environment injurious to health and welfare by neglect. The teen was then placed with a sister. In October 2020, the Hotline received a report that the teen was refusing substance abuse treatment services. The teen's sister stated she could no longer care for him due to his refusal to engage in services and continued drug use. DCFS moved the teen to a fictive kin placement, where he stole alcohol from his caretaker and was arrested. The teen had been placed with another sister but was on run when he died. The cousin's home was an unauthorized placement.

Child No. 66	**DOB: 07/2007**	**DOD: 05/2021**	**Accident**
Age at death:	13 years		
Cause of death:	Pending (coroner has not released the cause of death but has confirmed that the manner is accident)		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old was found in her bedroom unresponsive, cold to the touch, with white foam and blood coming out of her mouth, around 7:30pm. Her sister called 911 and she and their father attempted CPR. Paramedics transported the teen to the hospital, where she was pronounced deceased. The father reported he had last seen her awake around 1:30am the previous night, and he had also checked on

her around 9:00am that morning, but she was asleep. The teen's family reported she often slept late into the day and they suspected she had been using drugs. The Department opened an investigation into the death. The investigation is pending for death by neglect against the teen's father.

Prior History: In April 2021, the Hotline received a report that the teen called 911 and stated her father was abusing her. The father reported the teen and her older sister were fighting, so he tried to interrupt the argument, then the teen ran into the kitchen and grabbed the knife, which he wrestled away from her. Police took the teen to the hospital where she was psychiatrically admitted. The teen's older sister and adult half-brother reported the teen was aggressive. The sister denied that their father used physical discipline and the half-brother stated the father was not aggressive. The teen returned home following discharge from the hospital. The teen's sister stated there had been no physical incidents in the home since the teen returned from inpatient treatment, but the teen refused to go to therapy and refused to take her prescribed medication. The investigation was pending at the time of the teen's death. The Department later unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse.

Child No. 67	DOB: 08/2018	DOD: 06/2021	Accident
Age at death:	2 years		
Cause of death:	Gunshot wound of the head		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old was visiting his father's home, found his father's gun, and shot himself. The father, who worked as an armed security guard, returned home from work and set his loaded firearm on the floor near the sofa before falling asleep. When he awoke, he was late to pick up the toddler from the mother and did not put the gun away before he left the home. When they returned to his home, he placed the firearm on the TV stand and went into the backyard with the toddler and the dog. While the father was placing the dog in his kennel, as they came back inside, the toddler found the firearm and fired it. The Department indicated the father for death by neglect.

Prior History: In May 2021 the Hotline received a report of medical neglect to the toddler's 12-year-old brother by his mother. The 12-year-old slammed his foot in the door, thought he broke it and called the father. The father went to the mother's home to check on the minor and called the mother telling her she needed to come home and take the 12-year-old to the hospital. The father called later to check on the 12-year-old and found the mother had not taken him to the hospital. The father took the child for treatment and he was found to have a compound fracture. The reporter alleged the mother did not comply with instructions to follow up with the primary care physician and podiatrist, and that she had not provided copies of the children's medical cards to the father. The mother reported she was unable to leave work on the day of the incident, she sent a screen shot of the insurance card, and told the father he could take the 12-year-old to the ER. She stated she took the 12-year-old to a follow-up appointment where his cast was removed, and he was provided a walkable boot. In August 2021, the investigation was unfounded for medical neglect.

Child No. 68	DOB: 07/2019	DOD: 06/2021	Accident
Age at death:	22 months		
Cause of death:	Drowning		
Reason for review:	One unfounded and one indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-two-month-old was found unresponsive and floating in a pool at his maternal grandmother's home. He and his family were visiting his grandmother. She went to the store and his family stayed in the home. When she returned approximately 15 minutes later, the toddler was missing and the

back door, which she remembered locking, was unlocked. The toddler's 5-year-old brother stated he unlocked the door. The maternal grandmother found the toddler in the pool, pulled him out, and began CPR while the toddler's mother called 911 and his father assisted with CPR. The toddler was transported to the hospital by ambulance where he was pronounced deceased. The Department investigated and indicated the toddler's parents for death by neglect, inadequate supervision, and substantial risk of physical injury/environment injurious to health and welfare by neglect.
Prior History: In January 2020, the Department unfounded an investigation of cuts, welts and bruises to the deceased after a doctor determined marks were Mongolian spots. In April 2020, the Department opened another investigation that was later indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect to the then 9-month-old toddler and his then 4-year-old brother. In January 2021, the Hotline received a report of domestic violence between the parents and possible substance use. Both parents submitted to drug testing, which came back positive only for marijuana. During the investigation, the father moved out of the home but continued to co-parent, and both parents agreed to participate in intact family services, including domestic violence counseling and parenting classes. In April 2021, the Department unfounded the investigation. The family had agreed to intact services, but they refused when the worker came to the home.

NATURAL

Child No. 69	DOB: 05/2018	DOD:07/2020	Natural
Age at death:	2 years		
Cause of death:	Refractory septic shock due to aspiration pneumonia due to prolonged hypoxia		
Reason for review:	Unfounded child protection investigation within a year of the child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old medically complex child died. Her mother brought her to the hospital three days earlier after noticing she had been cold and listless for six hours. Hospital staff noted she was having trouble breathing, her temperature was too low to get an accurate reading and she weighed only 10 pounds. The toddler was intubated and admitted to the pediatric intensive care unit. She was an identical twin and had been born prematurely, at 26 weeks with medical complications arising from her prematurity. Her twin had died shortly after birth. The toddler had been diagnosed with organic failure to thrive, seizure disorder and hydrocephalus. The Department investigated the death and unfounded the investigation.

Prior History: In August 2019, the Hotline received a report following a physical altercation between the parents. The toddler's then 11-year-old sister witnessed the father push her mother down, and the mother was then four months pregnant. The father was arrested for domestic battery; police reported they had not had prior contact with either parent. The investigation determined that the sister was in the car when she witnessed the father push the mother who was trying to get into the father's home while they were arguing. The toddler's sister reported she had not seen the father since the incident; the mother reported they had separated, and she denied prior domestic violence in their relationship. The Department unfounded the investigation. The mother declined intact family services.

Child No. 70	DOB: 08/2020	DOD: 08/2020	Natural
Age at death:	2 days		
Cause of death:	Pulmonary hemorrhage		
Reason for review:	Pending child protection investigation; unfounded investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-day-old was pronounced deceased at the hospital. At birth, she had been diagnosed with a slow heart rate and a wound to her right forearm and was transferred to the neonatal intensive care unit. Her parents were at her bedside at the time of her death. The Department did not investigate the death, but there was a pending investigation at the time of her death because the Hotline received a report that the newborn's mother tested positive for marijuana while she was at the hospital for the birth. A hospital social worker informed the Department that the newborn's condition and death were not due to the mother's drug use.

Prior History: In September 2017, the child's older siblings came into care after the parents refused to participate in services after an intact family services case opened following an indicated investigation. In November 2018, the parents signed directed consents for the foster parents to adopt their two children and the adoption was completed the following year. In July 2020, the Hotline received a report alleging the mother gave birth prematurely, used drugs, and was very thin despite being seven months pregnant. The child protection investigator determined the mother was admitted to the hospital but had not given birth. The report was determined to be an unqualified report. In August 2020, the Hotline received a report that mother had given birth and tested positive for marijuana. The newborn was transferred to the neonatal intensive care unit at a children's hospital. Hospital staff stated the newborn's respiratory issues were due to her being born with a large hernia that displaced her organs, and she was not stable enough to undergo any surgeries. The mother was involved with prenatal after an ultrasound at 20 weeks showed medical

complications. Hospital staff stated there was nothing the mother could have done to prevent the newborn's condition. The investigation was unfounded.

Child No. 71	**DOB: 09/2011**	**DOD: 08/2020**	**Natural**
Age at death:	8 years		
Cause of death:	Respiratory failure due to spinal muscular atrophy type 1		
Reason for review:	Two unfounded and one indicated child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-year-old died at home having been in hospice care for six weeks. She had been diagnosed with spinal muscular atrophy type 1 at birth, a progressive illness, and depended on a ventilator. The Department did not investigate the child's death.

Prior History: In October 2019, the Hotline received a report that the mother left the child with her grandmother, who had not been trained on her care or approved by doctors as an appropriate caregiver. The mother stated the child's then 5-year-old brother was transported to the hospital after a seizure the week before, and she contacted an approved caregiver, but the approved caregiver was unavailable. She then contacted the child's grandmother and trained her on how to use the child's equipment, with instructions to call 911 if any issues arose. She stated she intended to have the grandmother attend trainings, but it was difficult to meet the doctor's schedule. The Department indicated the mother for inadequate supervision because a doctor stated a similar incident had occurred two months prior. In May 2020, the Hotline received a report after the child's 5-year-old brother was admitted to the emergency room with concerns about the child's hygiene, sores and cradle cap. The mother reported she was at work when the brother's caregiver called reporting his oxygen was low. She instructed the caregiver to change the tracheotomy tube and then to call 911 when that did not work. The Department unfounded the investigation. During the investigation, the brother had another seizure and medical staff offered end of life care and hospice services, which the mother accepted. The brother died at the family home two days after the investigation closed. In June 2020, the Hotline received a report that the mother was not properly caring for the child at night, as the child's diaper was often saturated with urine and feces in the morning with saliva in the stoma area and the mother often left the child's siblings in the care of the in-home nurse, or the child's 13-year-old sister when the mother was at work. The mother stated the other children, ages 11, 12, and 13, were old enough to care for themselves as long as another adult was in the home. The mother reported that she had another trained and approved caregiver on the days the nurse did not come to the home and she had never left the child's sister to care for her alone. The child's primary care physician reported no concerns. The child's sister stated she liked to help her mom take care of the child, but her mother never left her to care for her alone. During the investigation, the child was hospitalized with a respiratory infection. Upon discharge, the child was placed on hospice care. Approximately three weeks before she died, the Department unfounded the investigation.

Child No. 72	DOB: 08/2020	DOD: 08/2020	Natural
Child No. 73	**DOB: 08/2020**	**DOD: 09/2020**	**Natural**

Age at death:	Twin A – 0 days
Age at death:	Twin B – 10 days
Cause of death:	Twin A – Extreme prematurity Twin B – Cardiac arrest due to respiratory failure due to extreme prematurity
Reason for review:	Two unfounded and one indicated child protection investigations within one year of children's deaths
Action taken:	Full investigation pending

Narrative: The twins' 14-year-old mother gave birth to the twin A, at approximately 25 weeks gestation, in a bathtub of a hotel where she was staying with her adult sister. Twin A was pronounced deceased in the hospital emergency room, and it is unknown if she took a breath after delivery. While at the hospital, the mother gave birth to Twin B, who was transferred to the NICU of a children's hospital. The mother stated she did not know she was pregnant and had not received prenatal care. The Department opened an investigation of the mother for the allegation of substantial risk of physical injury/environment injurious to health and welfare by neglect to surviving Twin B. The mother was staying with her sister for the summer. Ten days after her birth, Twin B died. The Department unfounded the investigation, the mother moved back into the grandmother's home, and DCFS referred the family for intact family services. The Department did not investigate either twin's death.

Prior History: In August 2019, the Hotline received a report that the grandmother had been gone from the home for three days leaving the then 13-year-old mother alone without food, money, or a phone. The mother's then 22-year-old brother came to the home to care for her. The mother denied that she had been left alone overnight. She stated she did not like the grandmother's paramour and refused to go to his home, but there was always food available, and she knew how to contact the grandmother or other relatives in an emergency. The Department unfounded the investigation. In October 2019, the Hotline received a report that the twins' mother had gone missing after the grandmother told her to leave the house. The grandmother later sent the twins' mother to live with a relative after the grandmother found a positive pregnancy test. In February 2020, the Department indicated the grandmother for substantial risk of physical injury/environment injurious to health and welfare by neglect. The mother stayed with the relative who enrolled her in school. The relative also took the mother to have the pregnancy terminated. In June 2020, the Hotline received a report that the grandmother locked the mother out of the home. The mother and grandmother had a physical altercation, and family members reported the mother was the aggressor. The mother left to stay with a relative after the incident. Multiple family members reported the mother was out of control and they had no concerns about the grandmother's care for the mother's younger siblings. In July 2020, the Department unfounded the investigation and the mother remained with the relative. The Department offered services to the grandmother, but she refused.

Child No. 74	DOB: 04/2006	DOD:09/2020	Natural

Age at death:	14 years
Cause of death:	Cardio pulmmony failure due to dysphagia due to progressive dystonic quach plegic cerbral palsy [sic]
Reason for review:	Unfounded child protection investigation within one year of the child's death
Action taken:	Full investigation pending

Narrative: Fourteen-year-old died of cardiopulmonary failure. The medically complex teen had cerebral palsy and a history of seizures. This teen's death was not immediately reported to the hotline, and no child protection investigation was conducted. No autopsy was performed.

Prior History: The mother was involved in three unfounded child protection investigations between 2015 and 2019. Following the 2019 investigation, the Department opened an intact family services case which

was closed after 26 days because the mother declined services. In March 2020, the Hotline received a report alleging medical neglect and environmental neglect. The investigation was unfounded.

Child No. 75	**DOB: 07/2015**	**DOD: 09/2020**	**Natural**
Age at death:	5 years		
Cause of death:	Hypoxic ischemic brain injury due to acute respiratory failure due to moderate persistent asthma with acute status asthmaticus		
Reason for review:	Unfounded child protection investigation within a year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-year-old, diagnosed with asthma, woke up his mother because he could not breathe properly. His mother reported giving him his inhaler and then a breathing treatment, but he became unresponsive. His mother called 911; paramedics could not initially find a pulse or breathing movements but revived him and transported him to the hospital, where he was stabilized. He was then transferred to a children's hospital where he died the next day. The Department initiated an investigation of his death and found the child's mother gave him an inhaler prescribed to a relative, not the child. The child's school had expressed concerns for the child due to his consistent difficulty breathing and had requested an asthma action plan multiple times. The Department indicated the mother for death by neglect and indicated the mother and her paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect to the child's 2-month-old and 2-year-old maternal siblings.

Prior History: In May 2020, the Hotline received a report that the child's 2-year-old brother was outside without adult supervision for approximately 30 minutes, at which point a relative picked him up. The allegation stated the relative was a registered sex offender, and the child and his 2-year-old brother were in the care of relatives. The child's mother reported they were with the relatives for an overnight visit, and she was aware of the relative's history, but he had completed required treatment several years before. The relative reported he completed treatment and all required registration following his conviction in 1997. Medical professionals involved in the children's care noted no concerns. The Department unfounded the investigation for inadequate supervision and substantial risk of sexual abuse.

Child No. 76	**DOB: 08/2020**	**DOD: 09/2020**	**Natural**
Age at death:	1 month		
Cause of death:	Cardiorespiratory failure due to methicillin sensitive staph aureus due to extreme prematurity		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-week-old died at the hospital where he had been since birth. He had been born at 23 weeks gestation, weighing 1 lb., 10 oz. The Department did not investigate the infant's death.

Prior History: In July 2020, the Department opened an investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse to the infant's siblings. The mother, who was 20 weeks pregnant with the infant, was bleeding and presented at the emergency room. She was reported to be intoxicated. The father, who accompanied the mother to the hospital, was also reported to be intoxicated, and punched the ground before coming into the hospital, breaking his hand. The mother reported she had four children at home between the ages of 7 and 14. The maternal grandmother reported she was caring for the children at the time. She also reported the mother had an alcohol addiction but had been sober for a year. The maternal grandmother stated she did not allow the father to be around the children when she cared for them. Approximately two weeks after the hotline call, the mother went into premature labor. Hospital staff reported that the infant's parents had been appropriate with the infant and staff assisted them in getting into substance abuse treatment. The investigation remained pending when

the infant died in the hospital. In October 2020, the investigation was indicated for substantial risk of physical injury/environment injurious to health and welfare by abuse.

Child No. 77	DOB: 09/2020	DOD: 09/2020	Natural
Age at death:	9 hours		
Cause of death:	Respiratory failure due to meconium aspiration syndrome due to suspected sepsis due to HIE [hypoxic ischemic encephalopathy]		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn transported to a children's hospital immediately after birth. The mother received little to no prenatal care and did not seek medical attention after her water broke two days earlier. The mother reported being unaware that she was in labor. The mother tested positive for opiates at the time of his birth. The Department investigated the death and indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to her other children. The Department unfounded the mother for death by neglect.

Prior History: In August 2019, the Hotline received a report that the newborn's then 9-year-old sibling stated his then 11-year-old sibling had sexually molested him. The 9-year-old lived primarily with his father, who took him to the hospital for evaluation. The mother agreed not to allow the 11-year-old to be alone with any of the other children and stated she or a neighbor watched the children at all times. Following forensic interviews, law enforcement determined there was not enough evidence to issue a warrant and the case would be closed. The father petitioned for full custody of the 9-year-old. The Department assessed the other children as safe with their mother. The mother reported she re-arranged her home and work schedule to provide closer supervision. In October 2019, the investigation was unfounded.

Child No. 78	DOB: 07/2020	DOD: 10/2020	Natural
Age at death:	3 months		
Cause of death:	Liver failure		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was pronounced deceased at the hospital. The infant had been born premature, at 31 weeks gestation, with a collapsed lung. He was transferred directly to the neonatal intensive care unit staying there for over a month, before being discharged home. One week later, he was admitted to the pediatric intensive care unit. The infant had respiratory failure, liver failure, two liver transplants that had complications, and his health continued to decline. The Department did not investigate the death.

Prior History: In August 2020, the Department investigated the parents following a report that the infant was admitted to the hospital due to being lethargic. Tests showed his blood sugar levels were drastically low, and the mother reported having trouble waking the infant for feeding and he had taken in very little formula. Staff in the infant's primary care physician's office stated the mother called with concerns about the infant. At the doctor's office the infant began having trouble breathing and had low oxygen levels. The infant was hospitalized at a pediatric intensive care unit at a children's hospital in a neighboring state. The mother denied delaying medical treatment, reporting that in the week the infant had been home, he had seen his pediatrician twice. The infant had three maternal siblings at home who were healthy, and the father reported they were receiving support from family at that time. A hospital social worker reported that medical staff did not have concerns about neglect and the hospital was running tests, as they believed his liver failure had a genetic cause. Five days before the infant's death, the investigation was unfounded for inadequate food and medical neglect because hospital staff did not believe either allegation caused the infant's condition.

Child No. 79	DOB: 04/2017	DOD: 10/2020	Natural
Age at death:	3 years		
Cause of death:	Acute cellular rejection of orthotopic heart transplant due to complications of dilated cardiomyopathy		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Three-year-old who received a heart transplant in 2018 was found limp and unresponsive by her foster parent who brought her to the hospital where she was connected to life-sustaining supports (ECMO), intubation, and a ventilator. Lab tests revealed her anti-rejection medication levels were nearly undetectable, and she was in moderate to severe organ rejection. Five days after her arrival at the hospital, she met criteria for brain death. She was removed from life-sustaining supports and pronounced deceased. The toddler's autopsy noted that medication measurement was not reliable because the measured blood levels of the medication are heavily affected by dilution with fluids, blood transfusion, and the ECMO machine. The Department investigated and indicated the foster mother for death by neglect to the toddler after the investigation revealed the foster mother had not picked up the toddler's medication for the month of September despite several notifications from the pharmacy.

Prior History: In October 2018, the Department indicated mother for substantial risk of physical injury/environment injurious to health and welfare by neglect to the then 18-month-old child, who was awaiting a heart transplant. DCFS opened a high-risk intact family services case, and the mother was ordered to attend substance abuse treatment. In November 2018, the toddler received her heart transplant. In January 2019, the Department opened a new investigation related to the mother's substance use. The Department indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect and took the toddler into care. Two weeks later, temporary custody was granted. Following her heart transplant, the toddler remained at the hospital until February 2019. She was discharged into the care of a foster mother who was specialized in caring for medically complex children, and had experience caring for transplant patients. The placement worker made regular visits to the home and a nurse involved in the toddler's care had no concerns. In March 2020, the toddler was hospitalized for the flu, and the placement agency issued a notice of removal after the foster mother failed to visit the toddler for three days. The foster mother appealed. Doctors involved in the child's care disagreed with removing the child from the foster home, as they felt the foster mother followed through on appointments and sought medical attention when appropriate, and described her as responsible and responsive. A clinical placement review determined it was in the toddler's best interest to stay in the foster home. The caseworker continued virtual and in-person visits and noted no other issues prior to the toddler's death. The toddler's permanency goal was substitute care pending termination of parental rights, and her foster mother was considered an adoptive home.

Child No. 80	DOB: 10/2020	DOD: 10/2020	Natural
Age at death:	1 day		
Cause of death:	Multiple congenital anomalies incompatible with life, anhydramnios in the setting of absent right kidney and abnormal left kidney, severe intrauterine growth restriction, and congenital heart disease with vascular ring		
Reason for review:	Open placement case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn died at the hospital on the day of her birth. She had been born at 36 weeks gestation with multiple congenital abnormalities. Her birth was considered a "compassionate delivery," as hospital staff knew prior to her birth that the newborn would die from complications of her medical conditions, and medical interventions were not determined to be appropriate. The Department investigated the newborn's death and unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Prior History: In 2018, the Department opened two investigations against the mother that were indicated for allegations of cuts, welts, bruises, abrasions, and oral injuries by abuse; and substantial risk of physical injury/environment injurious to health and welfare by neglect. In September 2018, the mother's then infant child came into care. At case opening, services for the mother included parenting classes, mental health assessment, substance abuse assessment, and drug testing. Services for the father included establishing paternity of the newborn's then 2-day-old sister, mental health assessment, and substance abuse assessment. The sister was placed in a relative foster home. The mother visited inconsistently and was observed to be under the influence of substances during visits. In April 2020, the foster mother reported the mother was pregnant. The day of the newborn's birth, a child and family team meeting was held and discussion included changing the sister's goal from return home to substitute care pending termination of parental rights, with a plan for the sister's foster mother to adopt her.

Child No. 81	**DOB: 11/2015**	**DOD: 10/2020**	**Natural**
Age at death:	4 years		
Cause of death:	Cerebral palsy		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		
Narrative: Four-year-old medically complex child died. The child was on hospice and had been diagnosed with congenital hydrocephalus, epilepsy, and a swollen ventricle in cerebral part of the brain. The Department did not investigate her death.			
Prior History: In January 2020, the Hotline received a report the mother and her paramour use methamphetamine and the child's then 8-year-old brother witnessed his mother's paramour take a bag of white substance from a cabinet and the paramour made the brother taste it. The child's mother reported she was present for the incident and stated the white substance was diatomaceous earth (an ingestible, non-harmful substance with medical uses), which the child protection investigator observed. The investigation was unfounded.			

Child No. 82	**DOB: 11/2016**	**DOD: 10/2020**	**Natural**
Age at death:	3 years		
Cause of death:	Streptococcus pneumoniae bronchopneumonia due to Prader-Willi syndrome		
Reason for review:	Open intact family services case and pending child protection investigation at the time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Full investigation pending		
Narrative: Three-year-old was found unresponsive in the family home by his older siblings. When they could not wake the toddler, they called their mother, who had left the home approximately four to five hours earlier. The mother called 911 and arrived home before the ambulance. She began CPR, then the toddler was transported to the hospital, where he was pronounced deceased. The toddler had Prader-Willi syndrome, a rare genetic disorder that required close monitoring of his symptoms. The Department investigated the toddler's death and indicated the mother for death by neglect to the toddler, inadequate supervision to all six children, and environmental neglect to all six children.			
Prior History: In May 2019, DCFS opened two investigations against the mother. The Department indicated the mother in one investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect to the toddler and his older siblings. The Department unfounded the second investigation. In April 2020, the Hotline received a report that two toddlers were outside the home unsupervised and the same thing had happened within the previous two weeks. The mother admitted she had left the home to go to the store and had left the toddler's 13-year-old sister in charge. The 13-year-old stated she went to the bathroom and was unaware the toddlers could open the door. The child protection			

investigator instructed the mother to install additional locks, out of the reach of the toddlers. In May 2020, while the investigation was pending, the Hotline received a report that two toddlers were again left outside unsupervised and neighbors were intervening to keep them out of the street. The toddler's mother stated she had been home all day and the children were not in the street. She admitted to the prior incident in April but stated she had installed a latch to prevent the toddlers from leaving the home again. The mother agreed to intact family services. In June 2020, both the April and May investigations were indicated for inadequate supervision; the May investigation was later unfounded on appeal. An intact worker made an initial visit in June. Between June and July 2020, the intact worker attempted to visit six more times, but no one answered the door and the mother did not respond to the worker's texts or calls. Throughout August and September, the intact worker was again unable to reach the mother. In September 2020, DCFS requested a wellness check by local police, who reported no concerns. That month, the worker submitted a request for court involvement to the States' Attorney. Approximately two weeks before the toddler died, the mother had still not engaged with intact family services, and the Hotline received a report that the mother was leaving the toddler and his five siblings, unsupervised. The reporter also noted the toddler had a physical condition that required use of a feeding tube. The mother denied leaving the children unsupervised sending the younger children to daycare while the 13-year-old would stay home. The child protection investigator noted the toddler no longer used a feeding tube. While the investigation was pending, the toddler died. In December 2020, the investigation was indicated for inadequate supervision.

Child No. 83	**DOB: 08/2004**	**DOD: 10/2020**	**Natural**
Age at death:	16 years		
Cause of death:	Probable cardiac rhythmic disturbance due to myocardial fibrosis and hypertrophy		
Reason for review:	Youth in care; pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Medically complex 16-year-old died suddenly at the home of his relative caregiver. His foster mother found him unresponsive and not breathing. She called 911 and administered CPR until the ambulance arrived. Paramedics transported the teen to the hospital, where he was pronounced deceased. The teen had Duchenne muscular dystrophy, hypotonia, and depended on a wheelchair. The Department did not investigate the death.

Prior History: In June 2020, the Hotline received a report that the mother used heroin, was not providing the teen with necessary medical care, was giving him marijuana instead of his prescribed medications, and had sold his wheelchair to purchase drugs. The teen was reportedly in pain and losing weight. The Department took the teen into care and was placed with a foster parent who had custody of a sibling. The Department indicated the allegations of medical neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect and unfounded the allegation of substance misuse. Following placement, the teen began seeing medical specialists to address his needs. The father did not participate in services, and the mother was not consistent in her services. In September 2020, the Hotline received a report the father hit the teen's then 15-year-old cousin while he was visiting the foster home. The investigation remained pending at the time of the teen's death. The Department later indicated the father for cuts, bruises, welts, abrasions, and oral injuries by abuse and substantial risk of physical injury/environment injurious to health and welfare by abuse.

Child No. 84	DOB: 06/2020	DOD: 10/2020	Natural
Age at death:	3 months		
Cause of death:	Infant respiratory distress syndrome due to prematurity		
Reason for review:	Pending child protection investigation at time of child's deaths		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found cold, unresponsive, and not breathing. Her mother called 911 and paramedics transported the infant to the hospital, where she was pronounced deceased. The mother reported the infant had been born two months premature. The Department unfounded its investigation of the infant's death.

Prior History: In 2019, the Department indicated the mother for inadequate supervision to the infant's then 5-year-old maternal brother. In September 2020, the Hotline received a report that the mother was having a mental health crisis. Police conducted a welfare check and communicated to the child protection investigator that everything appeared okay in the home and the children appeared fine. The child protection investigator documented unsuccessful attempts to see the children and had scheduled a visit on the day of the infant's death. The investigation remained pending at the time of the death. The Department later unfounded the investigation.

Child No. 85	DOB: 03/2005	DOD:11/2020	Natural
Age at death:	15 years		
Cause of death:	Pulmonary hemorrhage due to aspiration pneumonia		
Reason for review:	Two unfounded child protection investigations and closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old was hospitalized for seven weeks and died at the hospital following a respiratory infection. The teenager had multiple medical conditions from brain damage he sustained during his birth due to lack of oxygen. Medical staff had no concerns about abuse or neglect upon admission. The Department did not investigate his death.

Prior History: In August 2020, the Hotline received a report that law enforcement responded to a domestic violence incident in the home while the teenager and three of his four sisters were present. The teenager's sisters reported the teenager was upstairs in his room, and the parents were grabbing and pulling the sisters while their parents argued over the mother taking the children to a nearby church for babysitting. The father was arrested for domestic battery and the mother obtained an order of protection against him. At the time, the parents were in the process of divorcing though they still lived together. The mother agreed to participate in intact family services. The investigation was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect to the teenager and the three sisters. Four days after the investigation closed, the Hotline received a report that the father had been threatening to hurt the children. The mother denied the father had made the threatening statements and had not been physically abusive toward them. In September 2020, the intact family services case was closed as the father was no longer living in the home, the family was financially stable, and the teenager was receiving medical care. One week later, the Department unfounded the investigation.

Child No. 86	DOB: 11/2020	DOD: 11/2020	Natural

Age at death:	2 weeks
Cause of death:	Bilateral adrenal hemorrhage due to sepsis
Reason for review:	Open intact family services case at the time of child's death; indicated child protection investigation within one year of child's death
Action taken:	Investigatory review of records

Narrative: Two-week-old was found by her mother in a pack and play, cool to the touch and not breathing. She was transported to the hospital by ambulance and pronounced deceased. The Department investigated the child's death and unfounded the parents for death by neglect.

Prior History: In March 2020, the Hotline received a report following a physical altercation between the parents; the father was intoxicated at the time of the incident. The newborn's siblings were home but asleep. The father was also a registered sex offender. The mother took the children to her sister's home, obtained an order of protection against the father and agreed to intact services. In May 2020, the case was brought to the state's attorney and the mother agreed to allow the grandmother to care for the children. In June 2020, the children went back with the mother and the court issued an order of protection on the minors that stipulated their father was not to be in the home. The court also ordered the parents to follow through with domestic violence services, individual counseling, substance abuse services, and parenting classes. The Department indicated the investigation for substantial risk of sexual abuse and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 87	DOB: 07/2003	DOD: 11/2020	Natural

Age at death:	15 years
Cause of death:	Diabetic ketoacidosis
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death
Action taken:	Investigatory review of records

Narrative: Fifteen-year-old was found unresponsive by his father when the father returned home from a hunting trip. The teen's father called 911, and attempted CPR. The teen's extremities were noted to be cold, but his core was still warm. He was pronounced deceased at the hospital. The teen had been diagnosed with diabetes in 2010. He had last seen his primary care physician within the two weeks prior and had his medication. The father reported he had difficulty engaging the teen in managing his diabetes. The father had been away for five days, but he stated he spoke to the teen the day before his death and had arranged for a family friend to check on the teen and cook for him. The Department unfounded its investigation of the teen's death.

Prior History: In July 2020, the Hotline received a report that police responded to the family home the day before due to a conflict between the teen and his father, and police arrested the father. The father stated he arrived home, smelled marijuana, and shook the teen awake. The teen reported his father was hitting his arm, not shaking him awake. The teen reported his arm hurt, but he refused medical attention and went to a friend's home to calm down. Police reported that the father and son had verbal arguments in the past and had some struggles since the teen's mother had died six years earlier. The teen's physician had seen him recently for diabetes management and did not have concerns about abuse or neglect. The father had been active in getting equipment to help manage the teens diabetes. The Department unfounded the investigation and provided referrals for grief and individual counseling and parenting classes for the father. Two weeks before the teen died, the Hotline received a report that the teen called police to report his father hit and scratched him. The investigator spoke with the officer who reported that the father denied hitting the teen saying he was defending himself from the teen. The officer said the teen could be defiant, but the father could be demanding. The child protection investigator made two attempts to visit the family before the teen's death but found no one home. Following the teen's death, the father denied hitting the

teen, but stated he would often have to defend himself if the teen became aggressive. The Department unfounded the investigation.

Child No. 88	**DOB: 06/2006**	**DOD: 11/2020**	**Natural**
Age at death:	14 years		
Cause of death:	High-grade neuroepithelial tumor with abdominal metastases		
Reason for review:	Open intact family services case at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old died at home after a six-year battle with cancer. An MRI showed the cancer had spread to his spine, and surgery was not an option due to the location of the tumor. He remained in the hospital while other treatment options were considered. His shunt stopped working properly and he was placed on a ventilator. Three days later, he was able to breathe on his own but was unresponsive. Three weeks before he died, he was released from the hospital to home hospice care. The Department did not investigate his death.

Prior History: In August 2020, the Hotline received a call that the teen had a diagnosis requiring intensive medical treatment, but he had not received his medication since May 2020 and he routinely missed medical appointments. The mother continued to reschedule appointments throughout the investigation for assorted reasons, including illness and health insurance concerns. The mother stated she would not give the teen a full dose of his chemotherapy medications. The teen's physician stated her failure to administer his medications and make his appointments as originally scheduled was medical neglect and resulted in a recurrence of the rare and aggressive cancer. The Department indicated the mother for medical neglect. In October 2020, the Department opened an intact family services case. The teen reported he only took one-third the dose of his chemotherapy medication due to its side effects. The caseworker helped the teen and his mother create a medication schedule and the teen agreed to take an additional medication recommended to reduce the severity of the side effects. One week later, the teen had an MRI that indicated the cancer had spread to his spine and was growing, and he was admitted to the hospital.

Child No. 89	**DOB: 05/2019**	**DOD: 12/2020**	**Natural**
Age at death:	18 months		
Cause of death:	Respiratory failure due to complications of prematurity		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eighteen-month-old medically complex child found unresponsive at approximately 6:40am after her apnea monitor sounded an alarm. Her mother called 911 and started CPR, and the toddler was transported to the hospital, where she was pronounced deceased. The toddler had been born premature, at 25 weeks and was diagnosed with chronic lung disease, developmental delays, and gastric reflux disease. She had a tracheostomy, gastrostomy tube for feeding, and relied on a ventilator. She spent her first 11 months of life in the hospital, and was in and out of the hospital after her discharge. The Department did not investigate the toddler's death.

Prior History: In May 2020, a nurse contacted the Hotline and reported the parents brought the toddler to the hospital earlier that day because her oxygen levels were falling; she needed to be transported to another hospital. The parents stated they would transport her themselves, but they had not arrived at the other hospital when the nurse called the hospital that evening. The reporter later confirmed they arrived shortly after the Hotline call. The mother stated she arrived later because she took the father home on the way to the second hospital. The toddler had been experiencing strange breathing patterns in the few days prior, and their in-home nurse instructed the mother to take the toddler to the hospital if she continued to have difficulty over the weekend. The father reported when they took the toddler to the first hospital, he

became upset when the nurse was unable to find a vein and was hurting the toddler. They were given the option to take the toddler to another hospital. The toddler's home health nurse worked in the home six days per week, and reported the parents were attentive and comforting to the minor. The Department unfounded the investigation for medical neglect. The family had no other children and no other involvement with DCFS.

Child No. 90	DOB: 03/2017	DOD:12/2020	Natural
Age at death:	3 years		
Cause of death:	Hypoxic ischemic encephalopathy due to cerebral palsy due to extreme prematurity		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Three-year-old medically complex child was taken to a local hospital for labored breathing and was subsequently transferred to a children's hospital. Three days before he died, the toddler was placed on a ventilator and a brain scan revealed no brain activity. The toddler had been born prematurely at 33 weeks with multiple diagnoses including cerebral palsy, seizure disorder, short gut syndrome, global developmental delay, and failure to thrive; depended on a gastrostomy tube and tracheotomy tube; and was non-verbal.

Prior History: In November 2018, the Hotline received a report that following the toddler's discharge from an extended hospital stay the mother failed to attend medical appointments and the child was admitted to the hospital for a week for failure to thrive. The Department indicated the investigation for medical neglect and referred the family for community-based services. In March 2019, the Hotline received a report that the then 2-year-old toddler was admitted to the hospital. The mother acknowledged he had been sick for at least a day before she brought him in, and hospital staff reported his condition could have been prevented if he had been brought in sooner. In April 2019, the Department took the toddler into care. The Department indicated the mother for medical neglect, and the toddler remained at the hospital after the investigation closed. In June 2019, the toddler was placed at a long-term care facility and began receiving occupational therapy, physical therapy, and developmental therapy. The toddler's mother was not compliant with reunification services that included parenting classes, parenting coaching, individual therapy, and anger management. The Department planned to transition the toddler to a specialized foster home.

Child No. 91	DOB: 02/2017	DOD: 01/2021	Natural
Age at death:	3 years		
Cause of death:	Septic shock due to peritonitis due to perforated gastric ulcer		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old died at the hospital from complications of a stomach and intestine surgery. He had been born with Dandy Walker syndrome, a rare genetic disorder. Other diagnoses including Joubert syndrome, global developmental delays, and hydrocephalus. He had received medical interventions including a ventriculoperitoneal shunt, gastrostomy tube, tracheostomy, ventilator, physical therapy, occupational therapy, and speech therapy. The Department did not investigate the toddler's death.

Prior History: The toddler's legal guardian was his maternal grandmother, who also had guardianship of his sister. His sister was also medically complex and had Dandy Walker syndrome. Their mother was unable to care for their special needs and gave guardianship to her mother following DCFS involvement. In 2018, the Department unfounded the grandmother for cuts, welts, and bruises by neglect to another child living in her home. In December 2019, the Hotline received a report that the toddler, who was brought to the hospital for a virus and fever, had a diastatic skull fracture, but no explanation was provided

for the injury. Medical staff could not determine the age of the injury, though it was not present at the toddler's last MRI six months earlier. Medical staff had no concerns about grandmother's care of the child, though they could not determine the cause of the fracture. In March 2020, the Department indicated an unknown perpetrator for the investigation because the toddler was not yet mobile, so he could not have injured himself; the toddler had many caretakers including in-home nurses; and it was uncertain when or where the incident took place.

Child No. 92	**DOB: 07/2020**	**DOD: 01/2021**	**Natural**
Age at death:	5 months		
Cause of death:	Sudden unexpected infant death		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-month-old was found not breathing and the father attempted CPR. The infant was transported to the hospital by ambulance, where he was pronounced deceased. The mother took him to his doctor the day before because he was congested. She was given eye drops and instructed to use saline for his nose, along with Benadryl. The parents stated they asked for an x-ray because they believed his breathing issues were more serious, but the doctor said it was not necessary as his lungs were clear and only his nose was congested. The parents reported he was acting normal the night before, and they placed him to sleep in his pack-and-play on a pillow to prop him up and aid his breathing. The mother awoke and fed the infant around 5:30am, then went back to sleep approximately 30 minutes later. She stated she placed him on his back, and he had not moved or changed positions between the time she put him back to sleep and when she found him unresponsive. The parents denied being informed of safe sleep practices when they were discharged from the hospital, but they knew the infant should not sleep with a blanket or toys. The Department investigated the infant's death and unfounded the parents for death by neglect.

Prior History: From April 2018 to January 2019, the infant's then 15-year-old mother and maternal grandfather had an intact family services case, with substance abuse counseling recommended for the mother and parenting classes recommended for the maternal grandfather. In July 2018, the mother was arrested for interfering with a police officer. She was released to the maternal grandfather and required to attend substance abuse treatment and mental health counseling as part of her probation. In January 2019, the intact family services case was closed, as the mother was compliant with the terms of her probation. In 2019, the infant's father was indicated for environmental neglect to the infant's then 2-year-old paternal brother. In August 2020, the Hotline received a report that the infant's maternal grandfather attempted suicide while the then 1-week-old infant and his 15-year-old maternal aunt were present in the home. The infant's mother was not present for the incident. The maternal grandfather was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect to the infant and his maternal aunt, but unfounded the same allegation by the maternal grandfather to the infant's mother.

Child No. 93	**DOB: 11/2020**	**DOD: 01/2021**	**Natural**
Age at death:	8 weeks		
Cause of death:	Sudden unexpected infant death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Eight-week-old was found not breathing in his parents' bed. His mother stated she had put him in the bed on his back, with a blanket, and with his head on a pillow. She advised she checked on him about an hour later, and he was still asleep, but he was unresponsive the second time she checked on him. The mother called 911 and attempted CPR until paramedics arrived. The infant was transported to the hospital where he was pronounced deceased. The mother reported the infant often slept in the parents' bed. The Department unfounded its investigation of the infant's death.

Prior History: In December 2019, the Hotline received a report that the infant's then 6-year-old sister watched the 1-year-old and 5-year-old siblings after school until their mother returned home from work. The 5-year-old and 6-year-old both denied being left unsupervised. Multiple family members reported they provided care for the children while their mother was at work, stated the mother did not leave the children unsupervised, and they had no concerns about the mother's ability to care for the children. In February 2020, the Department unfounded the investigation.

Child No. 94	**DOB: 01/2021**	**DOD:02/2021**	**Natural**
Age at death:	15 days		
Cause of death:	Bacterial pneumonia		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Investigatory records review		

Narrative: Fifteen-day-old was found not breathing lying in bed with her presumed father. Her parents started CPR and called for an ambulance. At the hospital, medical staff resuscitated her, then transferred her to another hospital, where she was put on life support. Two days later, the newborn died at the hospital. The Department investigated her death and unfounded the parents for death by neglect but indicated the mother for environmental neglect because the home had garbage, cockroaches, and rotten food throughout.

Prior History: In November 2019, the Hotline received a report about a domestic violence incident between the mother and her stepmother, which the newborn's then 3-year-old and 5-year-old siblings witnessed. The mother was unfounded because she attempted to get her children away from the situation quickly and immediately called police. An intact family services case was opened for assistance with housing, community resources, and mental health services. In July 2020, the intact family services case was closed after the mother had maintained suitable housing, her mental health assessment did not recommend any services, and she had her children participate in the recommended community services.

Child No. 95	**DOB: 01/2020**	**DOD: 02/2021**	**Natural**
Age at death:	1 year		
Cause of death:	Undetermined		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: One-year-old seemed ill when his parents picked him up from his grandparents' home. They gave him acetaminophen and placed him to bed around 11:00pm. Around 2:00am, he awoke and was fussy, so his father checked on him, then he went back to sleep in his playpen. Around 5:30am, the parents awoke and found he was not breathing. He had been sleeping face-down, with a pillow near his head, and two blankets. The child's body was observed to be in rigor mortis. The Department investigated the death and unfounded the parents for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Prior History: The toddler lived with his mother, father, and sister, and his parents had shared custody of the toddler's paternal half-siblings. In October 2020, the Hotline received a report that a babysitter found the 7-year-old brother displaying inappropriate sexualized behavior. The mother stated she was seeking counseling for the 7-year-old and 5-year-old half-brothers and planned to take all the children to the doctor. The mother reported she monitored their activities on the internet and TV. The children's pediatrician and teachers reported no concerns regarding the children's welfare. The investigation was unfounded for inadequate supervision.

Child No. 96	DOB: 02/2021	DOD:02/2021	Natural
Age at death:	4 days		
Cause of death:	Cardiogenic shock, hypoxic ischemic encephalopathy, and heart failure		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-day-old died at the hospital where he had remained following his birth. Medical professionals presumed he experienced spontaneous placenta abruption. The Department did not investigate his death.

Prior History: In September 2020, the Hotline received a report that the family home was cluttered, and the newborn's then 3-year-old brother had bug bites all over his body. The child protection investigator visited the home and observed the brother's bug bites. The child protection investigator did not observe insects, clutter, animal feces, or safety concerns in the home. The mother disclosed that she was concerned about mold which the landlord was informed of and the yard was being treated for fleas. She added their cats were not allowed indoors and the dogs were rarely inside. A collateral contact reported the home was kept clean and she had no concerns about the parents' care. The investigation was unfounded for environmental neglect.

Child No. 97	DOB: 07/2015	DOD:03/2021	Natural
Age at death:	5 years		
Cause of death:	Seizure disorder due to congenital anomalies of the brain		
Reason for review:	Closed high-risk intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-year-old child was found not breathing by his mother. Emergency services were called, and he was pronounced deceased upon their arrival. At the time of his death, the child had a feeding tube and appeared severely malnourished. He was born with hydrocephaly that required surgeries, and was blind, nonverbal, and immobile. The Department opened an investigation into the death and the child's sibling came into care. The investigation is pending for death by neglect against the child's mother.

Prior History: In June 2019, the Department opened an investigation following a report the mother failed to bring the child to necessary appointments to address his complex medical needs, including getting him a gastrostomy tube. The Department indicated the mother for medical neglect, and opened a high-risk intact family services case. The mother was cooperative with services and was successful in scheduling and taking the child to necessary medical appointments. The child gained weight, and his pediatrician reported no concerns. While the intact case was open, in April 2020, the mother gave birth to her second child. Mother was participating in a family enrichment program. In June 2020, the Department closed the intact family services case successfully.

Child No. 98	DOB: 08/2009	DOD: 03/2021	Natural
Age at death:	11 years		
Cause of death:	Chronic secretions due to severe spastic cerebral palsy due to anoxic brain injury		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Eleven-year-old was taken to the hospital where he was pronounced deceased. The child's father reported he had given the child acetaminophen earlier that day for a fever, then found the child unresponsive. The child had a long history of medical conditions including chronic secretion, severe spastic cerebral palsy, anoxic brain injury, spina bifida and a tracheotomy. The Department did not investigate the child's death.

Prior History: Between September 2018 and November 2019, DCFS opened five investigations into the family, two of which alleged medical neglect to the child. One investigation was closed in the initial stage,

and the remaining four were unfounded on the father; the mother was not involved with the children. In May 2020, the Hotline received a report that the child's father punched the then 12-year-old sister in the leg and slapped her. The sister denied the allegations and reported she felt safe in the home. The Department unfounded the investigation. In June 2020, the Hotline received a report that the sister stated her father had kicked and punched her. The father denied the allegations but stated he did sometimes get angry and yell, and he was willing to engage in supportive services. The sister denied being punched and kicked, but stated her father often yells. She stated she felt safe at home but was sometimes uncomfortable when her father disciplined her. The Department unfounded the investigation. Less than one week before the child died, the Hotline received a report that the father had consumed alcohol, then grabbed the sister's hair and threw her down, causing her to hit her head. The investigation was pending at the time of the child's death. In July 2021, the Department unfounded the investigation because the sister and father denied the allegations and collaterals reported that the father did not physically abuse the child.

Child No. 99	**DOB: 03/2021**	**DOD: 03/2021**	**Natural**
Age at death:	1 day		
Cause of death:	Cardiovascular collapse skeletal dysplasia		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Newborn had congenital anomalies (encephalocele and atrophic dysplasia), and died at the hospital the day she was born. The newborn's mother tested positive for marijuana the day before giving birth. The Department did not investigate the death.

Prior History: In May 2020, the Hotline received a report that the mother hit the newborn's then 12-year-old maternal half-sister, with her fist and with a belt. The mother admitted physically disciplining the sister because she was disrespectful but had not harmed her. In June 2020, the mother was incarcerated after the sister's father obtained an order of protection and the mother refused to turn over custody of the sister to her father. The Department unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse. In June 2020, less than three weeks later, the Hotline received a report that the mother physically abused the 12-year-old sister during an argument in the presence of a friend of the sister. The friend's mother stated she requested a welfare check from the police. The friend stated she was blocked from contacting the sister after the incident. The mother denied the child protection investigator access to her home, frequently interrupted the child protection investigator when they interviewed the sister, initially did not allow the child protection investigator to speak with the younger children, stating she believed the sister's father and godmother were trying to take the girl from her. The child protection investigator did not observe any injuries on the 12-year-old, who stated her mom yelled and spanked her with a belt. The child protection investigator later observed the other children, ages 7 and 10, and the children's pediatrician reported no medical concerns. In July 2020, the Department unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse.

Child No. 100	**DOB: 11/2014**	**DOD:03/2021**	**Natural**
Age at death:	6 years		
Cause of death:	Nemaline rod myopathy due to chronic respiratory failure with hypoxia, ventilator dependent, trach tube dependent due to bronchopneumonia status post right mastoidectomy status post chronic otitis		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Six-year-old medically complex child found unresponsive. Child had chronic pulmonary failure and was dependent on a tracheostomy and ventilator. She resided at a pediatric habilitation and

long-term care facility since the age of 2 and her mother had not visited for the two years prior to her death. Medical staff had no concerns about the circumstances of the child's death and no autopsy was performed. The Department investigated the long-term care facility for the child's death. The investigation is pending for death by neglect.

Prior History: In 2009, while two investigations were pending, the child's then 6-year-old brother was removed from the mother's care because she planned to return to her abusive paramour's home after the investigations closed. In November 2014, the child was born testing positive for cocaine and cannabinoids and came into care. The investigation was indicated for substance misuse by neglect. In August 2017, the child's mother gave birth to another child who tested positive for cocaine at birth and she disclosed she used marijuana during pregnancy and that child also came into care. That child's case remains open.

Child No. 101	**DOB: 12/2020**	**DOD: 03/2021**	**Natural**
Age at death:	2 months		
Cause of death:	Upper respiratory viral infection leading to cardiac respiratory arrest		
Reason for review:	Pending child protection investigation at time of child's death; two indicated child protection investigations within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Two-month-old brought to the hospital for vomiting three days before his death. Hospital staff informed the mother the infant had rhinovirus and he was discharged. While on the way home, the infant became unresponsive and the mother called 911. He was transported to the hospital, then went into cardiac arrest. The infant was diagnosed with pneumonia and had brain damage. Three days later, he was taken off life support and pronounced deceased. The Department did not investigate the infant's death.

Prior History: In October 2020 the Hotline received a report after police responded to a domestic violence incident between the mother and half-sibling's father while the half-siblings were present. Police arrested the mother, then the father left the children alone in the home. The parents reported they were in the process of divorcing. Approximately six weeks later, while the investigation was still pending, the Hotline received another report of domestic violence with the children present that was taken as related information. The father reported he obtained an order of protection against the mother and that she was not to have any contact with the children. In January 2021, the Department indicated both parents in the first investigation for inadequate supervision and substantial risk of physical injury/environment injurious to health and welfare by neglect. In December 2020, while the first investigation was pending, the Hotline received another report of domestic violence between the parents. The reporter alleged the parents were verbally fighting, then the mother grabbed a knife and threatened to slash the father's tires. Two weeks before the infant died, the Department indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect. In February 2021, while the second investigation was pending, the Hotline received a report that the infant had bruising on his face and back. The infant was seen at his primary care physician's office the day after the report, and medical staff noted no concern for abuse or neglect. The investigation remained pending at the time of the child's death. In May 2021, the Department unfounded the investigation because the infant's doctor did not have concerns about abuse or neglect.

Child No. 102	DOB: 01/2018	DOD: 03/2021	Natural

Age at death: 3 years
Cause of death: Delayed complications of group B streptococcus
Reason for review: Pending child protection investigation at time of death, child returned home within one year of death (split custody case)
Action taken: Full investigation pending

Narrative: Three-year-old suddenly became unresponsive while his mother was feeding him. His mother called 911 and he was transported to the hospital by ambulance while in cardiac arrest. The hospital continued life-saving efforts and intubation. After consulting with doctors, the toddler's mother chose to obtain a do not resuscitate order. Medical staff withdrew care and the toddler died less than 15 minutes later. The Department unfounded its investigation of the toddler's death.

Prior History: In 2019, the Department opened six child protection investigations on the mother. The first five investigations were unfounded, and the last investigation was indicated for medical neglect of disabled infants and substantial risk of physical injury/environment injurious to health and welfare by neglect. The Department took the toddler and his three siblings, then ages 2, 9, and 11 years old into care. Two months later, the toddler was returned to his mother's care. His 9-year-old sister was later placed with her father and his 2-year-old twin sister was returned to his mother's care. His 11-year-old brother remained in the relative placement. In February 2021, the Hotline received a report alleging the toddler's 9-year-old sister was afraid of their mother, as she drinks, and the father physically disciplines her. The investigation was still pending when the toddler died. The Department later indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse and inadequate supervision.

Child No. 103	DOB: 08/2018	DOD:04/2021	Natural

Age at death: 2 years
Cause of death: Hypoxia due to cerebral hypotonia and neuromuscular disease since birth
Reason for review: Unfounded child protection investigation within one year of child's death
Action taken: Full investigation pending

Narrative: Two-year-old medically complex child was feeling ill, and his mother observed reddish fluid in his feeding bag. The mother called 911. Responding paramedics attempted CPR and transported him to the hospital, where he was pronounced deceased. The toddler had been treated for neuromuscular heart disease since birth. The Department did not investigate the toddler's death.

Prior History: In December 2020, the Hotline received a report that the family home had a large broken window from a shooting a few months earlier, the mother left the children unsupervised, and the children were running in the street. The mother denied leaving the children unsupervised and stated the window was broken by her children. In February 2021, the Department unfounded the investigation.

Child No. 104	DOB: 11/2020	DOD: 04/2021	Natural

Age at death: 4 months
Cause of death: Shock and hyponatremic dehydration due to small bowel intussusception
Reason for review: Unfounded child protection investigation within 12 months of child's death
Action taken: Investigatory review of records

Narrative: Four-month-old had been found hot to the touch and not breathing. The mother's phone was not charged, so she attempted CPR and called out for the infant's maternal aunt, who lived with the family, to stay with the infant. The mother found a neighbor to call 911. Paramedics performed neonatal shock treatment and continued CPR while transporting the infant to the hospital, where he was pronounced deceased. The infant had been seen by his pediatrician the day before for a routine check-up, and was

mildly congested at the time, but his pediatrician had no concerns. The Department unfounded its investigation of the infant's death.
Prior History: In December 2020, the Hotline received a report against the infant's maternal aunt that alleged the infant's then 6-year-old sister was outside for about 15 minutes in only a diaper when the weather was below 50° F while the maternal aunt was arguing with someone. The aunt reported she lived with the infant's mother and three children, ages 6 years, 1 year, and the then 1-month-old infant. The aunt stated she did not have any children of her own in the home, and claimed that her 1-year-old child was her nephew. She stated the children were never unsupervised. The 6-year-old sister stated neither she nor the other two children had ever been left alone outside. After observing the children and speaking with the aunt, the mother, police, and collateral contacts, the Department unfounded the investigation.

Child No. 105	**DOB: 05/2005**	**DOD: 05/2021**	**Natural**
Age at death:	15 years		
Cause of death:	Chronic lung disease requiring tracheostomy and oxygen		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		
Narrative: Fifteen-year-old was transported to the emergency room after his father called for an ambulance. The teen was pronounced deceased in the emergency room. He had chronic lung disease since birth, and his respiration declined since he was hospitalized with COVID-19 ten months prior. The Department did not investigate his death.			
Prior History: In July 2020, the Hotline received a report of environmental neglect after paramedics responded to a 911 call that the teen was having seizures. The teen, who could not walk or talk, was lying on the floor in a blanket, was dirty and smelled foul, and his parents appeared to be hoarders. The responding paramedic told the child protection investigator that it was difficult to carry the teen out because boxes lined the hallway and walls, though the teen's parents appeared concerned and proactive in caring for the teen. The mother stated the boxes were medical equipment and supplies they had packed in preparation for a move to a larger apartment, and that the teen breathed easier and slept more comfortably on the floor. The teen had received weekly visits from a nurse practitioner, who had no concerns about the parents' care. The teen was hospitalized for respiratory distress caused by COVID-19, which was believed to cause his seizures. The teen was discharged to his mother after two weeks in the hospital. The Department unfounded the investigation.			

Child No. 106	**DOB: 03/2021**	**DOD: 05/2021**	**Natural**
Age at death:	8 weeks		
Cause of death:	Hepatic and renal failure due to Zellweger syndrome		
Reason for review:	Open placement case at time of child's death		
Action taken:	Investigatory review of records		
Narrative: Eight-week-old died in the hospital where she had remained since birth. She had been born at 26 weeks gestation with multiple medical complexities including a genetic mutation called Zellweger spectrum disorder. Her mother's pregnancy was complicated by a history of uterine rupture, abruption, trauma, and domestic abuse. The Department investigated the infant's death and unfounded her parents for death by neglect. The mother did not report her pregnancy or the infant's death to DCFS while working toward a return home goal for the infant's 5-year-old maternal brother.			
Prior History: The mother has three other children with a different father; two of those children are deceased as a result of the father's assault of one child and assault of the mother while she was pregnant. In October 2016, the infant's maternal brother died at the age of 3 years due to multiple injuries due to child abuse. The death was ruled a homicide. The father of the child was indicated for death by abuse; bone fractures by abuse; and cuts, welts, bruises, abrasions, and oral injuries by abuse to the 3-year-old;			

as well as substantial risk of physical injury/environment injurious to health and welfare by abuse to the sibling and has been convicted of murder. The Department indicated the mother for death by neglect; bone fractures by neglect; and cuts, welts, bruises, abrasions, and oral injuries by neglect to the 3-year-old; as well as substantial risk of physical injury/environment injurious to health and welfare by neglect to the sibling. The infant's then 16-month-old brother was placed in a relative foster home. While the investigation was pending, the mother gave birth to a child who died in the hospital. Her death was related to injuries sustained in utero during domestic violence between the mother and the father of the infant's maternal siblings. Her death was ruled a homicide. The Department indicated the maternal siblings' father for death by abuse and indicated the mother for death by neglect. At the time of the infant's death, his now 5-year-old maternal brother had an open placement case and resided in a relative foster home.

Child No. 107	**DOB: 05/2020**	**DOD: 05/2021**	**Natural**
Age at death:	11 months		
Cause of death:	Histiocytoid cardiomyopathy		
Reason for review:	One indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eleven-month-old found unresponsive on a queen-size pillow-top mattress. After placing the infant down for a nap, the father, who was the custodial parent, left the infant in the care of his girlfriend's relatives. When they returned approximately 50 minutes later, the infant was discovered unresponsive and they called 911. The infant was transported by ambulance to the hospital where she was pronounced deceased. The Department unfounded the father and his paramour for her death. The mother was not present at the time and did not live in the home.

Prior History: In October 2020 the Hotline received a report that the mother allowed gang members in the home and there had been a shooting, the home was dirty, the infant was not being properly cared for and was recently hospitalized for dehydration. The Department investigated the mother for substantial risk of physical injury/environment injurious to the infant. The mother told the child protection investigator the shooting involved a neighbor. She and the infant were not home at the time and she was looking to move out of the neighborhood. The investigator observed the home to be clean, with working utilities, and stocked with food. Two weeks later, while the investigation was still pending, the Hotline received a second report that the mother had dropped the infant off at someone's home without food or diapers and she had been using marijuana, alcohol, and ecstasy. A relative picked the baby up and told the investigator that the mother had been evicted from her home. Mother was investigated for inadequate supervision to the infant. The child protection investigator, who was unable to locate the mother, learned that two weeks after the second hotline call, the mother granted guardianship of the infant to the infant's maternal aunt until she could acquire stable housing; the child protection investigator observed the notarized statement. Subsequently, the child protection investigator received a text from the mother saying that the father could co-parent with the maternal aunt. The child protection investigator observed the infant in her father's home with no signs of abuse or neglect, and the father provided paperwork from the doctor's office where the infant had been seen for a well-child check. The mother was unfounded for the first investigation because the infant's pediatrician did not have concerns and the apartment was observed to be safe, with no evidence of suspicious activity, broken windows, bullet holes, or weapons. The Department indicated the mother for inadequate supervision – left in the care of an inadequate caregiver in the second investigation.

Child No. 108	DOB: 12/2019	DOD: 05/2021	Natural
Age at death:	16 months		
Cause of death:	Sudden unexpected death associated with systemic viral syndrome		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-month-old was found unresponsive in bed at 8:00am. He was last seen alive the night before by the mother's paramour, who was caring for the toddler and his sibling after the mother went to work at 5:00pm. The mother and her paramour brought the child to the hospital, and he was airlifted to a children's hospital and placed on a ventilator. A head CT scan showed he had ischemic injuries. The following day, his parents decided to remove life support and the toddler was pronounced deceased. The Department investigated and unfounded the mother and her paramour for the death.

Prior History: The infant lived with his mother, his 3-year-old sister, and his mother's paramour. The parents had split custody of him and his sister. In May 2020, the Hotline received a report that the parents got into an argument where the father pushed the mother down, and the infant's then 2-year-old sister witnessed the altercation. The father admitted he shoved the mother after she pulled on his sweatshirt just as police were arriving, and police arrested the father. Two days after the investigation opened, the court dropped the domestic violence charge, but a charge for resisting arrest remained. The father stated he had never hit the mother and would never harm her. Collateral contacts reported no other incidents of domestic violence. The Department unfounded the investigation. In October 2020, the Hotline received a report that the then 9-month-old toddler had a large burn on his finger. The mother reported the toddler was crawling when he grabbed a candle. She stated she took the toddler to the hospital immediately where he was treated for a second degree burn, and a follow-up appointment was scheduled with the toddler's pediatrician. The Department unfounded the investigation.

Child No. 109	DOB: 06/2011	DOD: 05/2021	Natural
Age at death:	9 years		
Cause of death:	Intracranial hemorrhage due to irreversible anoxic brain injury		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-year-old was watching a movie with his mother and siblings when he told his mother he had a headache, took ibuprofen, then collapsed. Paramedics stabilized the child en route to the hospital. He remained in critical condition at the hospital and was placed on a ventilator. He was unconscious and was found to have no signs of brain function. Two days later he was pronounced deceased at the hospital. The Hotline received a report alleging his mother waited 10 minutes to call 911 and that the home was uninhabitable. The Department did not investigate the death but indicated the mother for environmental neglect and unfounded her for medical neglect.

Prior History: Between 2008 and 2019, the child's mother was indicated four times for allegations of medical neglect or inadequate supervision to the child's older brother, who has severe mental and physical disabilities. At the time of the child's death, his older brother was living in a group home for people with developmental disabilities. Eleven days before the death, the Hotline received a report that the child's mother did not administer the brother's seizure medication while he was on his monthly visit with her. She told the investigator she did not remember the code for the medication box sent by the facility, so she administered medication left over from when he lived in the home. The investigation was ultimately unfounded.

Child No. 110	DOB: 05/2018	DOD: 05/2021	Natural
Age at death:	3 years		
Cause of death:	Cytomegalovirus pneumonia, post liver transplant		
Reason for review:	One indicated and three unfounded child protection investigations within one year of child’s death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old arrived at the emergency room unresponsive, with a distended abdomen, a body temperature of 90° F, and no pulse. Medical staff were unable to revive the toddler. The toddler had a diagnosis of transcarbamylase deficiency, required a feeding tube, and had received three liver transplants. His most recent transplant occurred approximately two years before his death. The Department did not investigate the toddler’s death.

Prior History: In June 2020, the Hotline received a report that children were running in the streets without adult supervision and had bruises on their faces. The reporter was also concerned about the toddler, who was on a feeding tube. Medical staff involved in the toddler’s care reported no concerns, no bruises were observed on the children and they denied being left alone. The investigation was unfounded. Four days after the investigation closed, the Hotline received a report that the children had bruises, the home was dirty, the children’s father would show up to the house drunk and carrying a gun, and a child who had disabilities was being left alone outside. The child protection investigator did not observed the children to have any bruises. The parents and the children denied the father coming to the home intoxicated with a gun. The toddler was in and out of the hospital during the investigation. The toddler’s in-home nursing services were terminated after the mother attempted to leave the children in the care of the toddler’s nurse to attend a job interview. The Division of Specialized Care for Children provided assistance and nursing services were later reinstated. Collateral contacts reported no concerns with the family. The investigation was unfounded. In November 2020, five days after the previous investigation closed, the Hotline received a report that the toddler’s mother declined speech therapy, physical therapy, and occupational therapy for the toddler. The services were voluntary and had moved to video calls due to the COVID-19 pandemic. The investigation was unfounded. In March 2021, the Hotline received a report that the father showed up at the home drunk and police had previously responded to the home for domestic disturbances. The mother reported she did not want the father in the home and the children sometimes let him in. Nine days before the toddler’s death, the Department indicated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect. The family agreed to community-based services, including mentoring services for the toddler’s 13-year-old brother, who had previously run away from home, as well as individual and family counseling, but services had not begun before the toddler died.

Child No. 111	DOB: 04/2017	DOD: 06/2021	Natural
Age at death:	4 years		
Cause of death:	Adverse effects of KCNT1 gene mutation		
Reason for review:	Youth in care; two indicated child protection investigations within one year of child’s death		
Action taken:	Investigatory review of records		

Narrative: Four-year-old was being cared for by her grandmother at another relative’s home. They noticed her breathing heavily and called 911. Paramedics started CPR and were unsuccessful in intubating the child as she had microlaryngoscopy, bronchoscopy supraglottoplasty, adenotonsillectomy, and Botox injections to her salivary glands the week prior. She was transported to the hospital and pronounced deceased. The child had several physical disabilities including: obstructive sleep apnea, seizures, Laryngomalacia, KCNT 1, gene de novo missense, Adenotonsillar Hypertrophy, bilateral impacted cerumen, and a gastronomy tube. Her life expectancy had been two to three years. The Department unfounded its investigation of the child’s death.

Prior History: In September 2020, the Hotline received a report that medical professionals were concerned about the then 3-year-old's weight, and the mother's admitting that she was not feeding the child as directed. A pediatrician determined the child being medically neglected, and she was taken into care. The next day, the Department opened an additional investigation against the child's home health nurse for failing to feed the child as directed. The investigation against the mother was indicated for burns by neglect, medical neglect, and malnutrition. The investigation against the child's home health nurse was indicated for medical neglect. The child remained in the hospital until November 2020, when she was discharged to a relative foster home where she received daily visits from a home health nurse. In January 2021, the child's foster parent reported being overwhelmed as the child was having seizures more frequently and she felt she could no longer care for her. The child returned to her mother's care under DCFS guardianship, with in-home services in place as the mother had been making progress in services. The DCFS case worker conducted regular visits to the home. The mother was also receiving wraparound services to assist with rent, utilities, and diapers.

Child No. 112	**DOB: 06/2021**	**DOD: 06/2021**	**Natural**
Age at death:	3 hours		
Cause of death:	Respiratory failure due to pulmonary hypoplasia; anhydramnios/Potter's sequence due to renal disease		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn died at the hospital, three hours after his birth, from genetic abnormalities that were detected during prenatal testing. The mother tested positive for cocaine, methamphetamine, and cannabis, but medical personnel could not determine that this played a role in the death. The Department did not investigate the mother for the death, but indicated the mother for substance misuse by neglect to the infant.

Prior History: In September 2020, the Hotline received a report that the newborn's 5-year-old brother could not move his arm. He had a large growth on his arm for over a year and small bruises on his arm, and the reporter had been told the parents grabbed him by the arm. The father reported the 5-year-old had been playing rough with friends the night before and complained about his arm hurting. The parents took the 5-year-old to the pediatrician, who reported the bruises were gone by the time he was seen. The father also told the pediatrician the mother grabbed the 5-year-old by the arm to prevent him from running into the street. The pediatrician reported the 5-year-old was seeing an orthopedist for the growth, and he had no concerns with the family. The 5-year-old confirmed the cause of the bruise to the child protection investigator and he was able his arm. The investigation was unfounded.

Child No. 113	**DOB: 07/2011**	**DOD: 06/2021**	**Natural**
Age at death:	9 years		
Cause of death:	Bronchial asthma		
Reason for review:	Open intact family services case at the time of the child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-year-old was hoarse and had tightness in his chest after being outdoors, so his father helped him start a nebulizer breathing treatment. Several minutes later, his father checked on him and found him slumped over and unresponsive. His father called 911 and the father's paramour began CPR. The child was transported to the hospital and pronounced deceased. The Department did not investigate the child's death.

Prior History: In February 2021, the Hotline received a report after police responded to a domestic violence call between the father and the father's paramour. No arrests were made. The child's sister reported she did not witness the argument. The Department unfounded the investigation. The children's

mother had died in 2019, and the Department referred the family for intact family services to include grief counseling. The intact family services worker visited the family regularly before the child died in June 2021 and noted the children, father, and home were appropriate during the visits.

PENDING

Autopsies for the following child deaths have not yet been released.

Child No. 114	**DOB: 10/2020**	**DOD: 11/2020**	**Pending**

Age at death: 2 weeks
Cause of death: Pending
Reason for review: Two unfounded child protection investigations within one year of child's death
Action taken: Investigatory review of records

Narrative: Two-week-old was found unresponsive, lying face up on a blanket. The mother began CPR while the maternal grandmother called 911. Upon arrival paramedics found the newborn was already deceased. He had been born premature, weighing 4 pounds and requiring a stay in the NICU. The mother stated he had been acting and eating normally the day before. Two days prior, at his last check-up, he had lost weight. The Department opened an investigation into the death. The investigation is pending for death by neglect against the infant's mother.

Prior History: The newborn lived with his mother, siblings, maternal grandparents, a maternal aunt, and the maternal aunt's children. In 2018, the aunt was indicated for environmental neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect. In May 2020, the Hotline received a report that approximately one month earlier, the maternal aunt's son had bruising after the aunt hit him in the neck with a belt, and the mother yelled at her children. The aunt and her children denied the allegations, as did the maternal grandparents. DCFS unfounded the investigation. In July 2020, the Hotline received a report that the maternal grandfather had been physically abusive with the newborn's 5-year-old cousin. The report also stated the mother, who was pregnant, had sought medical attention after a domestic violence incident with the grandfather in which he had pushed her, causing her to fall. The grandfather, the maternal aunt, the mother and a cousin denied the allegations. The newborn's cousin stated his grandfather sometimes spanks him, but his punishment was usually losing access to his games. The Department unfounded the investigation.

Child No. 115	**DOB: 01/2021**	**DOD: 01/2021**	**Pending**

Age at death: 5 days
Cause of death: Pending
Reason for review: Open placement case at time of child's death; one indicated and one unfounded child protection investigation within one year of child's death
Action taken: Investigatory review of records

Narrative: Five-day-old died at the hospital. She was born with complex congenital heart anomalies requiring medical interventions and surgical procedures. The Department did not investigate her death.

Prior History: In March 2019, DCFS investigated and later indicated the mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect relating to domestic violence between the parents. DCFS took the newborn's then 2-year-old and 10-year-old brothers into care and placed them with their maternal grandmother. The mother was tasked with completing assessments for substance abuse, domestic violence, mental health, and parenting capacity. The father was tasked with completing an assessment for domestic violence. While the case was open DCFS investigated and unfounded reports against the maternal grandmother. The mother complied with services. In September 2020, the brothers were returned to the care of their mother, with assistance from the maternal grandmother and a maternal aunt. In December 2020, the Hotline received a report following a domestic violence incident between the parents, in which the newborn's 13-year-old brother tried to intervene. Police arrested the father. DCFS returned the brothers to their maternal grandmother's care. The mother was advised to obtain an order of protection against the father and engage in domestic violence

counseling. The court ordered the brothers returned to the mother with the requirement that she uphold the order of protection and denied the father visitation. The day before the newborn's birth, the Department indicated the father for substantial risk of physical injury/environment injurious to health and welfare by abuse and indicated both parents for substantial risk of physical injury/environment injurious to health and welfare by neglect.

Child No. 116	**DOB: 01/2021**	**DOD: 01/2021**	**Pending**
Age at death:	0 days		
Cause of death:	Pending		
Reason for review:	Open placement case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn's mother began having contractions and 911 was called. The mother gave birth before the ambulance arrived. Paramedics found the mother performing CPR on the newborn when they arrived. The newborn was unresponsive and had no pulse. Toxicology results showed the newborn tested positive for opiates and methamphetamines. The Department opened an investigation into the death. The investigation is pending for death by abuse against the newborn's mother and father.

Prior History: In August 2017, DCFS investigated the mother for substance misuse by neglect to the newborn's then 2-day-old sister after the mother admitted to using opiates and cocaine during her pregnancy. DCFS opened an intact family services case, but the parents did not comply with services, including substance abuse assessments, and failed to participate in training on how to care for the newborn's sister, who had serious medical complications. In November 2017, both parents were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect. During the investigation, both parents tested positive for opiates and the children at home came into care. When the newborn's then 3-month-old sister was discharged from the hospital in January 2018 she was placed in a licensed foster home. In September 2018, she was placed with her siblings after their foster parent completed medical training. The parents did not consistently visit their children after they came into care. The parents eventually stopped engaging with the agency and visiting their children and the agency conducted a diligent search for the parents. A petition for termination of parental rights was filed in court. In December 2020, the agency learned the mother was pregnant. The placement case remained open at the time of the newborn's death.

Child No. 117	**DOB: 12/2020**	**DOD:02/2021**	**Pending**
Age at death:	8 weeks		
Cause of death:	Pending		
Reason for review:	Three pending child protection investigations at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-week-old was found unresponsive in bed with her mother and 10-year-old maternal sister. The mother began CPR while the sister called for an ambulance. Paramedics were unable to resuscitate the infant and she was pronounced deceased at the hospital. The Department opened an investigation into the death. The investigation is pending for death by neglect against the infant's mother.

Prior History: In January 2021, the Hotline received a report that seven months earlier, the father masturbated in front of the infant's 6-year-old paternal brother. The brother's mother stated the father downloaded pornography on the brother's computer tablet. The brother stated his father did not know he was present, and no one had inappropriately touched him or asked him to do anything with his private parts. The father denied the allegations and the pediatrician had no concerns. The investigation, which was pending when the infant died, was unfounded in May 2021. In February 2021, the Hotline received a report that the father went to the infant's mother's house, said he'd been awake for four days straight, punched her in the face while she was holding the then 6-week-old infant, and tried to wrestle the infant

from her arms. The Hotline received a second report that day stating while the father was holding the infant, the mother hit him in the face three times, and he may have defended himself because he was holding the infant. Police arrested the father. The infant's pediatrician did not observe any harm to the infant and had no concerns about the mother. An investigation on each parent was pending when the infant died. In April 2021, the Department unfounded both reports due to the parents' conflicting statements and lack of witnesses.

Child No. 118	**DOB: 08/2020**	**DOD: 03/2021**	**Pending**
Age at death:	6 months		
Cause of death:	Pending		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Six-month-old was found in bed, unconscious, and not breathing, by his mother. His mother reported she found him at approximately 7:00am but her cell phone battery was dead, and she could not call 911 until 7:51am. When first responders arrived at the scene, the infant's body was already in rigor mortis. The Department opened an investigation into the death. The investigation is pending for death by neglect against the infant's mother and father.

Prior History: In 2018, DCFS indicated the infant's father for substantial risk of physical injury/environment injurious to health and welfare by abuse and by neglect to the infant's then 1-year-old and 2-year-old siblings. In January 2020, the mother was unfounded for environmental neglect. In August 2020, four days before the infant's birth, the Hotline received a report that the infant's mother and maternal aunt were using drugs and alcohol, neglecting care for the infant's siblings, and the home had a mold problem. In December 2020, the Department indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect. During the investigation intact family services was discussed, but the case did not open until after the death.

Child No. 119	**DOB: 08/2020**	**DOD: 04/2021**	**Pending**
Age at death:	8 months		
Cause of death:	Pending		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-month-old was found unresponsive by her mother, who reported she put the infant down for a nap, then found her not breathing two hours later. The infant was transported to the hospital by ambulance, and medical staff were able to revive her. She was then airlifted to a children's hospital where she was later pronounced deceased. The Department opened an investigation into the death. The investigation is pending for death by neglect against the infant's mother and father.

Prior History: In November 2020, the Hotline received a report that police responded to a 911 hang-up call from the family home. The parents reported they had been yelling at each other but denied any physical fighting had ever occurred between them. Police observed a small scratch on the then 3-month-old infant's face and called an ambulance to the home. EMTs determined the scratch was an old injury. Police took the mother into custody on an outstanding warrant for a DUI, and she was released a few days later. During the investigation, the family moved, and DCFS attempted to reach the family but was unsuccessful for two months. In January 2021, the child protection investigator met with the family. The parents reported their relationship had improved and they both reported they had stopped drinking. The child protection investigator assessed the home as safe and the investigation was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect. In February 2021, the Hotline received a report that the mother attacked the infant's maternal grandmother, and the then 6-month-old infant was

present. Police responded to the home and arrested the mother for domestic battery. The mother reported she had a combative relationship with her mother, and they got into a loud argument, but denied the argument turned physical. The investigation was pending when the infant died. In July 2021, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect due to the mother's history of arrest, domestic violence relationships, aggressive behaviors, and failure to engage in services.

Child No. 120	**DOB: 04/2020**	**DOD: 05/2021**	**Pending**
Age at death:	13 months		
Cause of death:	Pending		
Reason for review:	Open intact family services case at time of child's death; one indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-month-old was found unresponsive by his father around 11:00am. The toddler was transported to the hospital by ambulance, where he was pronounced deceased. The father reported co-sleeping with the toddler as the father did not have a crib at his home. The toddler had been born premature, due to complications. He had a seizure disorder and was unable to take food by mouth. The toddler primarily lived with his mother, but she had recently become employed and he began staying with his father more often. The Department opened an investigation into the death. The investigation is pending for death by neglect against the toddler's father.

Prior History: The father lived with his father, brother, and sister. In July 2020, the Hotline received a report that the toddler's then 9-year-old cousin was begging for food, dirty with matted hair, and lived in a home with an infestation of mice, and frequent visitors who drank and used illicit substances. The child protection investigator observed the cousin to be clean. The cousin reported she had enough to eat and did not see people going in and out of the home. The father, who was frequently at the hospital attending to the toddler following his premature birth, had no concerns about the cousin's safety. The investigation was unfounded. In September 2020, shortly after the July investigation closed, the Hotline received a report following a fight at the family home, for which the toddler's then 9-year-old cousin was present. The father was listed as a non-involved subject. Police responded to the home to diffuse the situation and made no arrests. The cousin had not been left inside alone or unsupervised, and the adults involved reported telling her and the daughter of the grandfather's paramour to go inside when the fight began. The Department indicated the toddler's paternal aunt for substantial risk of physical injury/environment injurious to health and welfare by neglect and unfounded her for inadequate supervision. The aunt agreed to intact family services, and was recommended family counseling, individual counseling, housing assistance, and job assistance. The intact case was ongoing at the time of the toddler's death. The intact case later closed following successful completion of services. The toddler's father was not an active member of the intact case, there were no concerns regarding the toddler or his father, and the intact caseworker did not document any notes involving the toddler or his father.

Child No. 121	**DOB: 10/2012**	**DOD: 06/2021**	**Pending**
Age at death:	8 years		
Cause of death:	Pending		
Reason for review:	Closed placement case within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Eight-year-old was in a car accident and sustained fatal injuries. He was not properly restrained. His father's paramour was driving, and he, his father and four of his siblings, ages 3, 8, 11, and 12 were passengers. All of them sustained injuries and were treated at the hospital. The family was on

vacation. The Department opened an investigation into the death. The investigation is pending for death by neglect against the infant's father and the father's paramour.

Prior History: The child lived with his mother and had limited contact with his father. In October 2013 the child's three paternal half-siblings came into care after the father's paramour received a DUI with a child in the car. The half-siblings were initially placed with their maternal grandparents. In 2017, they were moved to a traditional foster home. At the end of 2017, the children were returned to their parents. In April 2019, DCFS opened a child protection investigation that was later indicated for inadequate supervision against the father's paramour and environmental neglect against the father and his paramour and the children came back into care. In December 2020, the court returned the child's paternal half-siblings to the father and his paramour.

Child No. 122	**DOB: 12/2020**	**DOD: 06/2021**	**Pending**
Age at death:	6 months		
Cause of death:	Pending		
Reason for review:	Open placement case at time of child's death; indicated child protection investigation within a year		
Action taken:	Investigatory review of records		

Narrative: Six-month-old was pronounced deceased at the hospital. He and his mother were staying at his aunt's home. The mother reported she fell asleep on the couch with the baby, finding him unresponsive when she awoke at 9:00am. She called for an ambulance but drove the infant to the hospital herself. The Department opened an investigation into the death. The investigation is pending for death by neglect against the infant's mother.

Prior History: Between 2009 and 2020, the mother was indicated in ten investigations for allegations of cuts, bruises, welts, abrasions, and oral injuries by neglect and inadequate supervision; and substantial risk of physical injury/environment injurious to health and welfare by neglect. She was unfounded in eight investigations. She had two intact family services cases. In July 2016, one week after the last intact case was closed, the Hotline received a report on the mother for substantial risk of physical injury/environment injurious to health and welfare and inadequate supervision and all six of her children came into care. Two months later, the Hotline received a report that the mother gave birth to her seventh child, who was also taken into custody. In April 2018, the mother gave birth to her eighth child, who was also taken into custody. Mother participated in services and in January 2019 was granted unsupervised visitation. A parenting capacity assessment determined that it would be in the family's best interest if the children were slowly staggered when returning them to the mother's custody. In June and August 2019, three of the children were returned home. The mother was granted unsupervised overnight visitation with the rest of her children. In May 2020, the 14-year-old reported witnessing a domestic violence during an unsupervised visit at the mother's home. The mother and paramour were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect and the mother obtained an order of protection against the paramour. In December 2020, the Hotline received a report that the mother gave birth to the infant, her ninth child. She was not due for another month, had not received any prenatal care, and fled the hospital with the infant. DCFS took protective custody of the infant, but the court immediately returned him home to his mother. The Department indicated the mother and her paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect. At the time of the death all the children were taken back into custody. The placement case remains open.

TWENTY-YEAR DEATH RETROSPECTIVE

FISCAL YEAR	2002-15		2016		2017		2018		2019		2020		2021		2002 - 2021		
															TOTAL	AVERAGES	
CASE STATUS	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	#	%
Youth in Care	322	21.8%	17	17.0%	20	18.3%	16	16.3%	22	17.9%	21	20.6%	11	9.0%	429	21	20.1%
Unfounded DCP	332	22.5%	23	23.0%	33	30.6%	37	37.8%	47	38.2%	29	28.4%	45	36.9%	546	27	25.6%
Pending DCP	185	12.5%	26	26.0%	22	20.4%	12	12.2%	19	15.4%	11	10.8%	20	16.4%	295	15	13.8%
Indicated DCP	99	6.7%	8	8.0%	8	7.4%	15	15.3%	9	7.3%	14	13.7%	14	11.5%	167	8	7.8%
Child of Youth in Care	45	3.0%	2	2.0%	1	0.9%	1	1.0%	2	1.6%	1	1.0%	0	0.0%	52	3	2.4%
Open Intact	212	14.4%	9	9.0%	15	13.9%	8	8.2%	8	6.5%	13	12.7%	14	11.5%	279	14	13.1%
Closed Intact	65	4.4%	7	7.0%	6	5.6%	3	3.1%	7	5.7%	5	4.9%	6	4.9%	99	5	4.6%
Open Placement/ Split Custody	89	6.0%	3	3.0%	2	1.9%	3	3.1%	4	3.3%	2	2.0%	9	7.4%	112	6	5.3%
Closed Placement/ Return Home	20	1.%	1	1.0%	0	0.0%	0	0.0%	2	1.6%	1	1.0%	3	2.5%	27	1	1.3%
Others	108	7.3%	4	4.0%	1	0.9%	3	3.1%	3	2.4%	5	4.9%	0	0.0%	124	6	5.8%
TOTAL	**1477**	**100%**	**100**	**100%**	**108**	**100%**	**98**	**100%**	**123**	**100%**	**102**	**100%**	**122**	**100%**	**2130**	**107**	**100%**

FISCAL YEAR	02-15	16	17	18	19	20	21	Totals 02-21
Total Deaths	**1477**	**100**	**108**	**98**	**123**	**102**	**122**	**2130**
Youth in Care	**322**	**17**	**20**	**16**	**22**	**21**	**11**	**429**
Natural	177	5	6	5	9	7	5	214
Accident	42	2	3	4	5	4	2	62
Homicide	69	7	6	4	6	4	2	98
Suicide	19	2	3	0	0	3	1	28
Undetermined	15	1	2	3	2	3	1	27
Unfounded Investigation	**332**	**23**	**33**	**37**	**47**	**29**	**45**	**546**
Natural	106	8	8	12	8	11	21	174
Accident	112	8	13	11	16	13	8	181
Homicide	54	4	6	4	11	1	6	86
Suicide	13	2	1	0	3	1	3	23
Undetermined	47	1	5	10	9	3	7	82
Pending Investigation	**185**	**26**	**22**	**12**	**19**	**11**	**20**	**295**
Natural	61	8	7	2	4	7	7	96
Accident	48	3	8	4	7	3	6	79
Homicide	34	3	1	4	2	1	3	48
Suicide	3	2	0	0	2	0	0	7
Undetermined	39	10	6	2	4	0	4	65
Indicated Investigation	**99**	**8**	**8**	**15**	**9**	**14**	**14**	**167**
Natural	36	3	3	4	3	6	4	59
Accident	31	3	3	2	3	3	4	49
Homicide	14	1	1	4	1	2	2	25
Suicide	2	1	0	0	1	1	2	7
Undetermined	16	0	1	5	1	2	2	27
Child of a Youth in Care	**45**	**2**	**1**	**1**	**2**	**1**	**0**	**52**
Natural	19	0	1	0	1	0	0	21
Accident	10	0	0	0	0	1	0	11
Homicide	8	0	0	0	0	0	0	8
Suicide	0	0	0	0	0	0	0	0
Undetermined	8	2	0	1	1	0	0	12
Open Intact	**212**	**9**	**15**	**8**	**8**	**13**	**14**	**279**
Natural	95	2	5	0	2	4	4	112
Accident	55	2	4	5	0	5	3	74
Homicide	29	1	2	1	2	2	3	40
Suicide	3	0	0	0	1	0	0	4
Undetermined	30	4	4	2	3	2	4	49

FISCAL YEAR	02-15	16	17	18	19	20	21	Totals 02-21
Closed Intact	**65**	**7**	**6**	**3**	**7**	**5**	**6**	**99**
Natural	20	1	2	1	5	4	2	35
Accident	21	2	1	1	2	0	2	29
Homicide	14	1	2	0	0	0	0	17
Suicide	0	0	0	0	0	0	0	0
Undetermined	10	3	1	1	0	1	2	18
Open Placement/Split Custody	**89**	**3**	**2**	**3**	**4**	**2**	**9**	**112**
Natural	55	1	2	2	2	1	2	65
Accident	16	0	0	0	1	0	0	17
Homicide	10	0	0	1	1	0	1	13
Suicide	0	0	0	0	0	0	1	1
Undetermined	8	2	0	0	0	1	5	16
Closed Placement	**8**	**0**	**0**	**0**	**0**	**0**	**1**	**9**
Natural	5	0	0	0	0	0	0	5
Accident	0	0	0	0	0	0	0	0
Homicide	3	0	0	0	0	0	0	3
Suicide	0	0	0	0	0	0	0	0
Undetermined	0	0	0	0	0	0	1	1
Adopted	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**4**
Former Youth in Care	**16**	**1**	**0**	**0**	**0**	**0**	**0**	**17**
Return Home	**22**	**1**	**0**	**0**	**2**	**1**	**2**	**28**
Interstate Compact	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**2**
Preventive Services	**35**	**0**	**1**	**1**	**0**	**0**	**0**	**37**
Subsidized Guardianship	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Child of Former Youth in Care	**4**	**0**	**0**	**0**	**1**	**2**	**0**	**7**
Extended Family Support	**13**	**1**	**0**	**0**	**0**	**0**	**0**	**14**
Child Welfare Referral	**23**	**2**	**0**	**2**	**2**	**3**	**0**	**32**

PART III: GENERAL INVESTIGATIONS

GENERAL INVESTIGATION 1

COMPLAINT

The Department was negligent in its duty to protect a 2½-year-old toddler by allowing him to remain in his mother's household pending a child protection investigation of allegations of cuts, bruises, and welts initiated after a mandated reporter contacted the Hotline reporting that the toddler came to daycare with a blood clot in his right eye, a greenish/bluish looking bruise on the side of his right eye, and two linear scratches on his neck. Two months later, while the first investigation was pending, a second Hotline call came in after the child again came to daycare with extensive bruising in various stages of healing.

INVESTIGATION

During the first child protection investigation, the mandated reporter shared that the child had similar injuries to the face and neck that subsequently healed when the 19-year-old mother brought the toddler to daycare for enrollment approximately 10 days earlier. Despite multiple facial injuries to a child under 3, the call floor worker at the State Central Register did not code the call as action needed, but as a regular response. On-call child protection staff made a good faith attempt to see the toddler and interview the mother the day after the Hotline call. The primary child protection investigator and supervisor were assigned four days after the Hotline call. However, the child protection investigator did not see the toddler until six days after the initial Hotline call when conducting a visit at the toddler's daycare. Daycare staff reported to the child protection investigator that the mother had no explanation for the toddler's injuries at the time of enrollment in the program and that she had recently relocated to the area. When asked about the second set of injuries, the mother told daycare staff that the scratches on the neck were eczema and provided the name of the toddler's pediatrician prior to their move. The mother also cited a fall the toddler had at daycare earlier in the month as an explanation for the injuries to the forehead. However, daycare staff documented the fall and did not believe the fall was related to the current injuries. Daycare staff reported the child often appeared resistant to leave with the mother at the end of the day and required soothing from staff. The mother lived with another person and had been seen bringing two other children to drop off in the mornings. Staff did not know the mother's relationship to the other person in the home or the children. The child protection investigator observed scratches on the left side of the toddler's forehead, a greenish bruise on his right check and a patch of redness on the left cheek. The toddler told the child protection investigator the injuries happened when he "got hurt," but could not identify who hurt him. The investigator uploaded photos of the injuries that daycare staff had taken six days earlier as well as photos taken that day. The investigator called and updated the supervisor, who instructed the investigator to contact the mother and ensure the child received a medical evaluation for the injury. The investigator assessed the toddler as safe and documented that the mother expressed a willingness and ability to protect her child, completing this assessment without speaking to the mother or observing the home environment. In an interview with OIG, the child protection investigator could not provide an explanation for the assessment.

Over the next five days, the investigator attempted to reach the mother through calls and an unannounced visit to the home. During the attempted home visit, an unidentified man answered the door, reporting the mother was at work. The investigator did not obtain any additional information about the person or other members of the household. The investigator reached the mother by phone, two weeks after the Hotline call. The mother reported her work schedule impacted her ability to meet with the investigator. The mother denied injuring her child and reported that he fell frequently. The mother explained that she recently moved to the area and lived with her friend but denied her friend caused the injuries to her child. The investigator instructed the mother to take the

toddler for a medical evaluation for his injuries. The mother had not obtained a primary care provider in the new community, and thus was instructed to take the toddler to the emergency room. The mother agreed to try and have the toddler seen by a doctor and to meet the investigator at the home, but no dates were secured. During this time, the toddler remained in the mother's care with no explanation for the injuries, no contact with prior medical providers, no assessment of the home, no in-person contact with the mother and assessment of additional household members.

Over the next three weeks, the investigator continued to have difficulty reaching the mother or seeing the home despite having a previously scheduled visit. The investigator notified the supervisor of the difficulties who instructed the investigator to continue efforts and send a letter to the home. The mother's collateral contact had no concerns, and local law enforcement reported no dispatches to the mother's address.

Nearly two months after the Hotline call, the investigator was able to complete a visit to the mother's home. The mother explained that her child fell a lot as the reason for the injuries. The mother denied abusing the toddler because she had been abused by the toddler's father, which resulted in her ending the relationship and moving. The investigator observed the toddler in the home but did not interview any other household members. Three days after the investigator observed the toddler in the home and two months after the first Hotline call, the Hotline received a second report of more bruising to the toddler and protective custody was taken. The allegation of cuts, welts, bruises was subsequently indicated against the mother to the nearly 3-year-old because the toddler had multiple injuries that the mother could not adequately explain, and she did not secure a medical evaluation.

RECOMMENDATIONS

1. Allegations of cuts bruises and welts made by a mandated reporter to a child 3 and under should be reviewed by a State Central Register (SCR) manager to determine the appropriate response.

The Department agrees. SCR administrators completed the following: issued a practice clarification notice to all hotline staff regarding the response code for bruising of children 6 and under to the head, neck, face or soft tissue area; the notice was also reviewed and discussed in all team meetings; 1:1 supervision with the hotline worker regarding this issue; for six months all calls involving allegation 11 were reviewed by supervisors; taken by all hotline staff for children 6 years and younger with bruising on the face, neck, head or soft tissue area. This practice is ongoing. Supervisors continue to review this allegation and approve the intake; and supervisors continue to review calls involving allegations 11 monthly. The additional reviews will ensure the hotline staff continue to reflect this practice clarification in their work.

2. This report should be shared with the Acting Deputy Director of Child Protection.

The Department agrees. The report was shared with the Acting Deputy Director of Child Protection.

3. The supervisor should be counseled on this investigation. This report should be shared and reviewed with the supervisor as part of that counseling session.

The Department agrees. The employee retired from the Department.

4. The investigator should be counseled on this investigation. This report should be shared and reviewed with the investigator as part of that counseling session.

The Department agrees. The employee was issued a written reprimand.

GENERAL INVESTIGATION 2

COMPLAINT When a 17-year-old youth in care with behavioral and mental health challenges ran away from the group home, staff failed to immediately attempt to locate the missing youth.

INVESTIGATION The family was involved in two prior unfounded child protection investigations that alleged alcohol abuse by the youth's father and physical abuse. Throughout much of the youth's childhood, the youth received outpatient services for behavioral issues and was first psychiatrically hospitalized for two weeks at the age of 5, at which time the youth was diagnosed with oppositional defiant disorder, ADHD, and impulse control. The family struggled to care for the youth in their home due to the youth's aggressive behavior towards household members. When the youth was 14 years old, an intact family services case was opened to assist the family, however, following an incident where the youth physically assaulted the father and threatened to kill the father, the youth was psychiatrically hospitalized. The parents refused to allow the youth to return to their home and the Hotline was contacted. While the child protection investigation was pending, the then 15-year-old youth was taken into protective custody and screened into court on a dependency petition due to exhibiting behavior that could not be addressed in the care of the parents.

The youth was placed in a residential treatment program for over two years. While placed at the residential program, the youth was psychiatrically hospitalized multiple times. When the youth was 17 years old, the youth was moved to a therapeutic group home after threatening staff at the residential program and refusing to return to the placement. The youth was placed at the therapeutic group home for three months. During those three months, the youth's violent outbursts and suicidal ideation continued. Prior to the placement disruption, the 17-year-old left the group home and was not located until five days later, when police were notified that the youth was attempting to board a Greyhound bus. The youth was taken to the hospital after being located.

The OIG investigation revealed that following the 17-year-old's unauthorized departure from the therapeutic group home, group home staff failed to follow Procedures 329.10, *Locating and Returning Missing, Runaway and Abducted Children* which require that group home staff, within one hour of realizing that a child in their care is missing, report any missing child or youth to:

- The local law enforcement agency; Caregivers must obtain the number of the missing person report from the law enforcement officer taking the report and provide the report number to the DCFS Child Intake and Recovery Unit;
- The child's case manager/worker (if after hours, the worker should be notified on the next business day); and
- The Child Intake and Recovery Unit (CIRU) (1-866-503-0184).

If the caregiver is in a residential facility, group home or shelter, the appropriate facility staff will also be responsible to:

- In accordance to Procedures 331, *Unusual Incidents*, complete the CFS 119 Unusual Incident Report (UIR); and
- Complete the CFS 906-E, after the child has been missing for 24 hours.

The group home also had an internal Runaway Prevention Plan that required contact with law enforcement, case management staff, and the Child Intake and Recovery Unit within one hour, which was not followed. Police, caseworkers and the Child Intake and Recovery Unit were not notified until two days after the youth went missing. In addition, there was not a coordinated effort by group home staff and the caseworker to locate

the youth until four days after the unauthorized departure and subsequent disappearance from the therapeutic group home. Given the youth's significant mental health needs, history of substance misuse, aggression and illegal behavior when on run, a concerted effort to locate the youth was warranted.

RECOMMENDATIONS

1. This report should be shared with the therapeutic group home to address the deficiencies in responding to the youth's unauthorized departure from the group home.

The Department agrees. The Inspector General shared a redacted report with the therapeutic group home.

2. The therapeutic group home staff should receive training on the requirements of Procedures 329, *Locating and Returning Missing, Runaway, and Abducted Children*. In addition, this report should be used as a training tool for group home staff on reporting runaway youth to ensure a coordinated effort with all involved parties (i.e. DCFS, CIRU, Law Enforcement, biological parents and other support persons).

The Department agrees. The assigned residential monitor supervisor has coordinated with the group home and Child Intake and Recovery Unit (CIRU) on Procedures 329 training. In addition, the report has been shared to serve as a training tool for group home staff on reporting runaway youth to ensure a coordinated effort with all involved parties (i.e. DCFS, CIRU, Law Enforcement, biological parents and other support persons).

3. This report should be shared with the DCFS residential monitor assigned to the group home.

The Department agrees. The report was shared with the DCFS Residential Monitor and Supervisor.

4. This report should be shared with the youth's current DCFS supervisor and case manager for ongoing case management planning. If the youth returns to placement, case management staff should consider a no violence contract with notification to the Court, and if appropriate, adult probation, for violation of the terms of the contract.

The Department agrees. The report was shared and discussed with the current supervisor and the case manager.

5. This report should be shared with the DCFS Child Intake and Recovery Unit (CIRU) for quality assurance purposes.

The Department agrees. The report was shared with the Child Intake and Recovery Unit for quality assurance purposes and to provide additional training to the involved agency.

6. The Department should develop placement options that provide long term stability for the Department's most aggressive youth that encompasses a strong clinical component to meet the mental and behavioral needs of these youth.

The Department agrees. Residential programs have been developed to meet the needs of youth in care requiring specialized services. The Department continues to develop additional resources to meet the needs of youth with aggressive behavior.

7. A redacted version of this report should be shared with DCFS Clinical, Department of Healthcare and Family Services, Department of Human Services and the Department of Juvenile Justice to address the critical need to develop placement resources for youth that have a history of severe mental illness and aggression.

The Department agrees. The report was shared with DCFS Clinical and will be shared with the other three agencies.

8. This report should be shared with the youth's guardian *ad litem*. The Department should advocate for a coordinated effort in ensuring the youth receive and engage in mental health services while also complying with any court ordered sentences.

The redacted report was shared with the youth's Guardian *ad litem*.

GENERAL INVESTIGATION 3

COMPLAINT

An Administrative Law Judge (ALJ) falsified the hearing date on a written recommendation sent to the Director of DCFS following an expungement appeal hearing of an indicated child protection investigation. The complaint also alleged that the ALJ engaged in *ex parte* communication with an appellant's attorney when the ALJ contacted the attorney to request an extension for a recommendation without involving or notifying opposing counsel from the Department.

INVESTIGATION

OIG investigators found that the incorrect date entered in the recommendation in question was due to a clerical error and not misconduct by the ALJ. The ALJ did engage in an *ex parte* communication with the attorney in a literal sense, however, OIG declined to assess whether the *ex parte* communication was somehow improper under the Administrative Hearings Unit's (AHU) policies or applicable legal and ethical standards, as such an assessment is outside OIG's purview.

However, in the course of investigating the above matters, OIG investigators did identify and investigate several inconsistencies in orders written by the ALJ, both in the case that was the subject of the above-referenced complaint and in three other cases. OIG investigators determined that the four orders contained falsehoods, including purported hearings, in a misguided attempt to extend statutory deadlines.

Specifically, OIG investigators found four fictitious continuance orders in four different expungement appeal cases. The four orders state that the ALJ requested and obtained agreements from all parties involved for continuance hearings, all of which were to take place by phone on the same date. The effect of the orders was to change the due date for the statutory 90-day time period between the party's agreement and the date listed on the orders, artificially extending the ALJ's time to complete the recommendations to the Director. If that time frame had not been extended, the recommendations would have been overdue and any sustained finding by the ALJ could have been overturned as a result. However, the evidence obtained by OIG investigators, including the ALJ's own admissions, established that the ALJ neither obtained agreements from the parties for the continuance hearings nor conducted the hearings at all.

Moreover, the dates on the continuance orders, which purportedly represent when the ALJ prepared them, also appear to have been false. All four orders were dated on the day of, or soon after, the expungement hearings, months before any reasonable person would know that an extension would be needed. The dates appear to represent the ALJ 's attempt to "back-date" the orders in a further attempt to avoid missing the applicable deadlines and to obscure her failure to meet the deadline for completing the written recommendation. If the indicated findings were overturned, the cases would not be contested in Circuit Court, as only the alleged perpetrator can appeal to the Circuit Court. However, if the indicated finding is upheld, especially on cases that far exceeded the 90-day timeframe, such as the ones illustrated in this report, the hearing could be contested and would likely bring more scrutiny to the actions of the ALJ. When questions arise on one of an ALJ's recommendations, it can call into question all recommendations.

There was no indication that the ALJ intentionally falsified the expungement appeal hearing date in the recommendation submitted to the Director, as alleged in the OIG complaint. A support staff member entered the last hearing date in the tracking data base which was the date on the fictious continuance hearing order that the ALJ created. The clerical staff and the ALJs themselves are expected to ensure that the correct dates, times and case numbers are in the decisions. Clerical staff enter the information based on the tracking data base which should align with the information provided by the ALJ.

OIG found problems with AHU's case tracking, that in two circumstances, resulted in inaccurate hearing dates being provided in the recommendations to the Director. The dates were added in the recommendation by clerical staff based upon the AHU case tracking system. However, if updated orders are not issued by the ALJ and thus not entered in the tracking system, the date on the recommendation will be entered as the last known activity. Additionally, it was learned that ALJs receive e-mail reminders of the 90-day due dates; however, once the cases exceeded the 90 days, without current continuance orders entered, there were no other reminders or "ticklers" generated. Lastly, there is a mechanism within AHU case tracking system to identify an incorrectly written order that would shorten the due date; however, there is no mechanism in the tracking system to identify an incorrect order that inaccurately extends the 90-day due date.

The ALJ used the continuance orders as a tool to artificially change the due dates of the four cases in question. Not only is creating a fictitious order itself unacceptable, but the act calls into question the recommendations. In the four recommendations reviewed, the ALJ far exceeded the 75-day due date for AHU review leaving only a few days/hours for the Director's review. The ALJ's actions resulted in limited time for AHU and the Director's representative to review the recommendations for accuracy and sound legal judgment.

RECOMMENDATIONS

1. The Administrative Law Judge should be discharged.

The Department agrees. The employee was discharged.

2. The Department should refer this matter to the DCFS Ethics Officer for review of the Administrative Law Judge's conduct for potential violations of the Illinois Rules of Professional Conduct, the State Employees and Officials Ethics Act, and/or other applicable ethical codes.

The Department agrees. The matter was reviewed by the DCFS Ethics Officer.

3. The Department should determine whether there is a means to vacate the Director's decisions that follow the Administrative Law Judge's recommendations in the cases discussed in this Report.

The Department agrees. The Administrative Hearings Unit continues to discuss potential remedies, but vacating decisions is unlikely.

4. The General Counsel or her designee should review all of the Administrative Law Judge's cases in the past two years which recommended overturning and expunging an indicated finding to identify continuance orders in those cases with the same indication of fraud as the orders discussed herein, specifically continuances ordered after the completion of the appeal hearing. The Department should also determine if this is a practice inappropriately employed by other Administrative Law Judges.

The Department agrees. The Administrative Hearings Unit leadership's review of the Administrative Law Judge's cases to date has been extensive, and is ongoing, but nearing completion. Hundreds of audio recordings of hearings have been reviewed to facilitate completion of many cases with missing written orders and

recommendations. Additional review measures have been put in place to ensure other Administrative Law Judges are not following this inappropriate practice.

5. The Administrative Hearings Unit should develop a mechanism for tracking pending recommendations, including overdue recommendations.

The Department agrees. Prior to 2021, the Administrative Hearings Unit tracked recommendations through the VMI database. In 2021, additional measures for tracking recommendations have been put in place, and further additional measures are still being considered. New measures implemented so far include (1) more detailed instructions for Administrative Law Judges following completion of a hearing; (2) multiple internal audits have been completed, resulting in discovery of additional improvements needed in Administrative Hearing Unit practices; (3) Administrative Law Judges must now provide weekly confirmation of completion of orders; (4) In addition to the use of the VMI database, Administrative Hearings Unit staff are also cross checking recommendation due dates, and creating a monthly report with the data regarding completion of Final Administrative Decisions.

6. The Administrative Hearings Unit should develop a practice to address delays in completing expungement appeal recommendations.

The Department agrees. Throughout 2021, Administrative Hearings Unit leadership worked directly with Administrative Law Judges to streamline recommendations with a view toward reducing the writing time. Support staff have also been integrated into the recommendation writing process prior to submittal of recommendations for final approval.

GENERAL INVESTIGATION 4

COMPLAINT

An adoption assistance agreement allowed for an adoptive parent's relative to provide therapeutic day care for her child to be paid for by the Department. However, the complaint alleged that the adoptive parent submitted requests for payment for therapeutic day care services outside the customary process and for services not actually provided. Further, the adoptive parent reported that Department staff members, in previous years, advised the adoptive parent to continue submitting requests for day care reimbursements even though the relative was no longer providing the service, as their subsidy under the adoption assistance agreement was at the maximum amount and could not be increased.

INVESTIGATION

The OIG could not definitively determine from interviews and the available documentary evidence precisely how many of the reimbursements the adoptive parents received over the years were fraudulent. Indeed, some reimbursements were legitimate as the relative provided daycare services for several years. OIG did determine, however, that the reimbursements received during the summers of 2018 and 2019 should not have been paid. During those summers, the minor was employed as a student worker at an Illinois state agency, but the adoptive parents received reimbursements for full-day day care services on days that payroll records show the minor was at work.

The adoptive mother readily acknowledged to OIG investigators that she billed the Department and received reimbursements for day care services even after her relative had stopped providing the service. She claimed that she did so with the full knowledge and consent of DCFS staff members due to the fact that the subsidy payments she had been receiving under her adoption assistance agreement were insufficient to cover her child's care and needs. OIG investigators were unable to determine specific DCFS staff members the adoptive mother worked with over several years that explicitly told or even actively allowed her to continue submitting requests

for therapeutic day care solely as an increase of her subsidy. OIG investigators did find that current and recent staff members had allowed her to circumvent usual practices in submitting and processing requests for payment. The current adoption worker, and the worker just prior to her, reported that they believed the relative was providing therapeutic day care. Thus, they acted in the way that their predecessors had, that is, they received the payment requests directly and referred them to the vouchering unit for payment, which was not DCFS's usual practice.

The State of Illinois provides a monthly subsidy to eligible adoptive parents. Adoption agreements often provide for payment for services the child may need. In this case, therapeutic day care was included. The child was 4 years old at the time of the adoption and there was a clear need for the service. What becomes more questionable, though, is the need for the service as the child aged, as the adoptive parent was submitting invoices because they felt that they needed the money and not because they were using the day care.

The provider in question is an approved and trained therapeutic day care provider. Also, the adoption assistance agreement stated that the child was receiving therapeutic day care at the time of the adoption and recommended that those services continue post adoption. Thus, it is reasonable to give the benefit of the doubt as to reimbursements where there is no proof of illegitimacy. Obviously, legitimate reimbursements owed do not lose legitimacy or somehow become fraudulent solely due to DCFS employees' failure to follow DCFS's normal vouchering protocols.

OIG investigators found 55 days during the summers of 2018 and 2019: 1) on which state employment records show the minor was employed as a student worker; *and* 2) for which the adoptive parent represented the minor received therapeutic day care services and that she paid the relative for those services. For all but four of those 55 days, the minor worked a state employee's full day (7.5 hours or at least 7 hours on two days), while also supposedly receiving nine hours of day care. Based on the $12 per hour rate purportedly charged by the relative, and the total of 483 hours of services purportedly provided on those 55 days, the adoptive parent requested and received $5,796 (483 hours x $12 per hour) in reimbursements for which there appears to be proof of illegitimacy.

The Department should not have paid for a full day of therapeutic day care while the state also was paying for a full day's work. A state employee may need reasonable accommodations or may require extra care in which a caretaker may be needed and still be able to perform their job. However, the adoptive parent sought reimbursement for therapeutic day care, not for care related to enhancing independence.

Though the question of the appropriateness of the day care service arose, OIG investigators did not determine whether therapeutic day care is a service that the minor still needs. That should be determined by a review conducted through DCFS Clinical, the DCFS Medical Director, and the Division of Nursing. As the adoptive parent reported providing the care in the home, and the minor is over 18 years old, there is a possibility they could be paid through the Medicaid program which pays family members as care givers.

This investigation does not seek to diminish the care that the adoptive parents have provided their child. However, another problem lies in the way in which they were able to circumvent the usual system. DCFS workers interviewed readily acknowledged they continued the practice because it had "always been done that way." Seven workers had been assigned to the adoption case over the years. OIG investigators were not able to interview all of the prior workers. While it is important that a Department which serves children and families of various needs not be so rigid as to make getting needed services difficult and bureaucratic, a general structure is needed to serve all families. OIG is not recommending any changes to the Department's vouchering structure and protocol. The failure in this case appears to be that the normal protocol simply was not followed.

Finally, OIG takes no position and makes no recommendation regarding how, or even whether, DCFS should seek some measure of relief from the adoptive parents relating to the fraudulent reimbursement requests and payments.

RECOMMENDATIONS

1. The Inspector General will refer this report to the Illinois State Police for evaluation of possible criminal fraud by the adoptive parent.

The Department agrees. The Inspector General shared a redacted report with the Illinois State Police.

2. The Inspector General will share this report with the Inspector General for the government office that employs the adoptive parent.

The Department agrees. The Inspector General shared a redacted report with the corresponding agency's Inspector General.

3. The adoption case should be reviewed by the DCFS Medical Director, a representative from the Division of Nursing, a representative from DCFS Clinical, and a representative of Illini Care to determine what are the needed services that can be adequately addressed through the provisions of the subsidy and Medicaid Managed Care Services.

The Department agrees.

GENERAL INVESTIGATION 5

COMPLAINT

The Department failed for over three years to fill the vacant positions of Indian Child Welfare Act (ICWA) Specialists, a position required under the Department Procedures 307, and there was no evidence that the Department engaged in "active efforts" as it relates to the implementation and administration of ICWA as defined in Department procedures.

INVESTIGATION

For over three years, The Department has not been in compliance with Procedures 307, *Indian Child Welfare Services*, since the Department has not employed or contracted any individuals in the official capacity of ICWA Specialist. The Department is in compliance with ICWA's notification requirements because staff members of the Office of Affirmative Action (OAA) have taken on duties normally performed by the ICWA Specialists to ensure that Native American children involved with DCFS are properly identified and are afforded the rights and protections under ICWA. However, certain responsibilities that had been managed by the previous ICWA Specialists are not being appropriately maintained, such as recruiting Native American foster homes and engaging in community outreach with Native American organizations. Procedures 307 was last revised in 2015, however, in June 2016, the federal government issued a new rule on ICWA. The new rule defined various terms in ICWA, including "active efforts."

The OAA is currently working to ensure that Illinois is complying with the federal requirements of ICWA; however, it is clear that the ICWA Specialist vacancies need to be filled. This is especially apparent in the extremely low number of Native American foster homes that have been recruited according to the latest available reporting. The ICWA Specialists also are needed at DCFS to better engage the Native American communities and restart the Indian Child Welfare Advisory Council. Relationships with these organizations need to be strengthened so that they can also serve as resources in recruiting additional Native American foster

homes. Increasing the number of foster homes in Native American communities will benefit the children who are eligible under ICWA, allow for more placement resources for the Department, facilitate Illinois's compliance with the federal statute, and fulfil the underlying purpose of ICWA.

It is also apparent that OAA needs to have better communication with Illinois Native American organizations regarding the ICWA Specialist issues. These organizations were not consulted about a posting to fill two vacancies for the ICWA Specialist before it was placed on the website, which was why the OAA received immediate complaints about the postings. OAA needs to have a better relationship with these organizations for a number of reasons. Due to their experiences, the Native American organizations have unique insight on what qualifications the ICWA Specialists need to be successful in their role. These organizations will also serve as a valuable resource in promoting the ICWA Specialist posting to qualified candidates. Therefore, the OAA needs to consult Native American organizations prior to reposting the ICWA Specialist position to ensure it attracts suitable candidates.

Prior to the ICWA Specialist positions being reposted, the posting also should be reworded to clarify the requirements of the candidates. The posting sections "Minimum Required Qualifications" and "Education and Experience Preferred" should be combined and clarified to indicate exactly what is required of the candidate and what is preferred. OAA should refer to postings for current DCFS open positions and the 2016 ICWA Specialist description for examples on how to reword the new ICWA Specialist posting. Additionally, it is understandable that there is legal concern regarding the ICWA Specialist posting having the requirement that the candidates be members of a Native American tribe. The 2016 posting did not include this requirement, and the OAA did find qualified candidates by asking the interviewees about their relevant experiences. Therefore, the ICWA Specialist posting should require candidates to have experience working with Native American organizations or programs.

The Department needs to expedite discussions with CMS regarding the ICWA Specialist positions being transferred from contractual positions to permanent staff positions within DCFS to better ensure stability. The ICWA Specialists help ensure that DCFS complies with federal regulations, and these positions should not be subjected to a lack of employment security.

The Department should complete a review of the current ICWA cases at DCFS to ensure that the active efforts have been properly implemented in each of these cases. After issuing the new federal rule, the Bureau of Indian Affairs at the U.S. Department of the Interior provided the state governmental entities with guidance on active efforts. Illinois needs to ensure that it is in compliance with these federal regulations, and that the members of the ICWA cases are receiving the appropriate services.

RECOMMENDATIONS

1. The Department needs to fill the vacancies of the Indian Child Welfare Act Specialists. In attempting to fill these positions, the following guidelines should be considered: (a) The posting for the Indian Child Welfare Act Specialist positions should require candidates to have experience working with Native American organizations or programs. (b) Office of Affirmative Action should not be required to wait until the Office of Child and Family Policy makes a determination on Procedures 307, *Indian Child Welfare Services*, to rewrite and repost the positions of Indian Child Welfare Act Specialist. (c) Before posting the Indian Child Welfare Act Specialist position, Office of Affirmative Action should consult with any Native American organizations that initially issued a complaint to Office of Affirmative Action about the previous posting to better ensure that the posting will attract qualified candidates.

The Department agrees. Both Indian Child Welfare Act specialist positions were filled. The specialists are highly qualified, have experience working with the Native American community and are verified tribal members.

2. Central Management Services should be provided with a copy of this report to expedite discussions of the Indian Child Welfare Act Specialist positions being transferred from contractual positions to permanent staff positions within DCFS.

The Department agrees. The Indian Child Welfare Act specialist positions were filled and both specialists are DCFS employees.

3. The Department must review Procedures 307, *Indian Child Welfare Services*, to ensure compliance with the 2016 federal rule regarding the Indian Child Welfare Act.

The Department agrees. This project will be reviewed by the Office of Child and Family Policy in 2022.

4. The Department should conduct a review of all Indian Child Welfare Act cases to determine that active efforts have been applied to all of these cases and appropriate services are being provided.

The Department agrees. The Division of Quality Enhancement completed a review of the 29 youth in care that were deemed to be eligible cases for the Indian Child Welfare Act review. Reviewers identified inconsistencies in thoroughly capturing and documenting potential Native American affiliation in a timely manner. Improvement is needed during initial case planning regarding identifying potential Native American affiliation. Other areas of opportunity for improvement include 1) documenting efforts to communicate with the tribe, 2) forming Child and Family Team Meetings with all stakeholders, and 3) the use of information in supervision to aid in decision-making. The Department continues to improve on these practices.

GENERAL INVESTIGATION 6

COMPLAINT

A private agency child welfare specialist falsified contact notes in the State Automated Child Welfare Information System (SACWIS).

INVESTIGATION

OIG substantiated the allegation that the child welfare specialist falsified SACWIS notes on seven cases while employed by a private agency. During the investigation, OIG investigators learned that after the private agency terminated the child welfare specialist's employment, the Department hired the child welfare specialist, despite the preliminary suspension of her Child Welfare Employee License (CWEL). Once notified of the preliminary suspension of her CWEL, the Department placed the child welfare specialist on desk duty.

The child welfare specialist failed to maintain required contact with children in care, foster parents, and birth families as provided in the Department's COVID-19 policy guide and falsified contact notes in SACWIS to show that she made the required contacts. The private agency discovered alleged instances of falsification, conducted an internal investigation, and took appropriate action with regards to the child welfare specialist's employment. OIG independently corroborated the falsified contact notes and initiated action against the child welfare specialist's Child Welfare Employee License based on the falsified notes.

After separating from the private agency, the child welfare specialist applied for employment at another private agency, declaring that all statements and answers on her application were true and complete. However, child

welfare specialist misrepresented on the employment application that she was still employed by the private agency from which she had separated. The child welfare specialist also applied for a position at DCFS and certified on her DCFS employment application that all information on the application was true and accurate. The child welfare specialist, however, omitted from her DCFS application that her employment at the private agency had ended. On interview, the child welfare specialist made false statements to OIG regarding the status of her private agency employment.

The OIG investigation also found that the child welfare specialist failed to comply with Department Rule 412, *Licensure of Direct Child Welfare Employees and Supervisors*, when she failed to notify the CWEL Unit of any changes in her address. The child welfare specialist's failure to keep the CWEL Unit apprised of her most current address caused unwarranted delays in the child welfare specialist receiving certified mail notifying child welfare specialist that her child welfare employee license had been preliminarily suspended.

The child welfare specialist also caused delay in the OIG investigation when she failed to promptly respond to OIG requests for interview. When the child welfare specialist finally cooperated with an OIG interview, OIG investigators found that child welfare specialist was untruthful and provided responses that were inconsistent with documented evidence gathered by OIG.

To address the issue of the child welfare specialist being untruthful to prospective employers about the status of her child welfare employment and child welfare employee license, the Office of Learning and Professional Development has issued a Standard Operating Procedure requiring the CWEL Unit to track any preliminary action taken against a child welfare specialist's child welfare employee license. The protocol requires that the CWEL Unit to take measures to inactivate the child welfare specialist in CYCIS and to notify the Agency Performance Team of the preliminary action to ensure that a case-coverage plan is activated during the preliminary CWEL action.

RECOMMENDATIONS

1. The Department should pursue disciplinary action of the child welfare specialist, up to and including discharge.

The Department agrees. The employee resigned.

2. As the Department Representative, OIG will file charges to revoke the child welfare specialist's Child Welfare Employee License pursuant to DCFS Rule 412, *Licensure of Direct Child Welfare Service Employees and Supervisors.*

The Department agrees. The Inspector General filed charges against the employee's Child Welfare Employee License.

3. The Office of Employee Services and the Child Welfare Employee Licensure Unit should develop and implement a process to ensure Child Welfare Employee License verification prior to making an offer of employment to a candidate for a position requiring a Child Welfare Employee License.

The Department agrees. The Office of Employee Services will add the following question to the CFS-717H, preliminary hire form for candidates to complete: 1.) Have you been issued a Child Welfare Employee License license in prior employment? A.) If the answer is Yes, is the license in good standing? B.) If the license is not in good standing, why not? Once the Office of Employee Services receives this information, they will send it to the Office of Learning and Professional Development to review and verify prior to making an offer of employment. The Department will also notify Child Welfare Employee License in case the discharged employee seeks a direct service role in the private sector.

GENERAL INVESTIGATION 7

COMPLAINT

A same-sex couple fostering a 4-year-old boy alleged discrimination when the child was removed from their care after he displayed perceived sexualized behavior at daycare and on the bus. Following a Hotline call made by the daycare provider, a child protection investigation was opened, and the 4-year-old boy and the couple's 10-year-old adopted son were temporarily removed from the home pending Victim Sensitive Interviews of the children.

INVESTIGATION

During the course of an open intact case, a child protection investigation was initiated after the boy's biological parents refused to remove him from a home where an individual, who was previously indicated for sexual abuse, was living. DCFS took custody of the boy and initially placed him in a licensed foster home. After there were allegations of corporal punishment, the boy was removed from that home and placed in a second licensed foster home consisting of same-sex parents and their adopted son.

Approximately seven months after the second placement, a daycare provider called the hotline alleging that the 4-year-old boy asked a peer to touch his "Pee Pee". The boy was re-directed, and the foster parents were notified. The next day, another incident took place on the bus in which the boy was found in the back of the bus with his pants down and reportedly "exploring himself". The daycare provider reported to the hotline that there had not been any prior sexualized behavior, the boy was progressing well, and his foster parents were very involved. The daycare provider did not identify a perpetrator when reporting the behavior to the Hotline. A child protection investigation was initiated for allegation 22, Substantial Risk of Sexual Injury - Option C- "Persistent, highly sexualized behavior or knowledge in a very young child (e.g. under the age of five chronologically or developmentally) that is grossly age inappropriate and there is reasonable cause to believe that the most likely manner in which such behavior was learned is in having been sexually abused."

State Central Register administrative staff acknowledged to OIG investigators that the behavior described in the hotline call was age normative behavior and that the Hotline call floor worker never should have taken the report for investigation, but rather taken as information only, and referred to the foster child's caseworker for further assessment. The call floor worker was retrained as a result.

The child protection investigation was identified as a "facility report" as it involved a youth in care in a licensed foster home. OIG investigators found that upon initiation of the child protection investigation, the child protection investigator asked the foster parents to abstain from contact with either child. The 4-year-old youth in care foster child was removed per Department procedure and placed in respite care. OIG investigators found that current procedures do not allow the completion of a child endangerment risk assessment protocol (CERAP) of biological or adoptive child when the investigation is identified as a facility report. Without the benefit of a risk assessment, the foster parents were also asked to make a "care plan" for their 10-year-old adopted child. The 10-year-old was to stay with a family member outside of the home, pending a Victim Sensitive Interview (VSI). The parents reportedly requested and were denied supervised visitation though Department procedures expressly allow supervised contact as an option. The family complied under duress with the "care plan," a term that does not exist in Department rules or procedures. The family was provided no documentation about removal of either child.

OIG investigators found that within seven days, the child protection investigator was informed that the VSI was declined by the agency as there was not enough evidence to warrant an interview. As a result, the child protection supervisor directed the investigator to close the case. The couple's adopted son was returned to their care, however, per Department procedure, the 4-year-old foster child was unable to be returned until the child protection investigation was closed. OIG investigators found that there was no investigative activity for 36 days

following the adopted son's return and the investigation was not closed for 50 days following the supervisor's directive to close the case.

Once the investigation was unfounded, the foster parents declined to allow the foster child back into their home fearing the potential for further trauma to their adopted son if another allegation was made against the family and the adopted son was again forced to be removed. Both the foster care agency and the foster parents identified the lengthy duration of the investigation as a factor in the decision to not allow the foster child back into their home. The foster care agency supervisor stated that the foster parents were one of the best that the agency had worked with and that the foster child had made much progress while in their care.

The OIG investigation found problematic decision-making regarding the Hotline call but did not find evidence that the foster parents' sexual orientation was a factor in the decision making. The Hotline call should not have been taken as an investigation given that a 4-year-old's exploration of genitalia is within normal limits of behavior. The decision to remove the 4-year-old foster child and deny contact with the adopted son is consistent with Department procedures, but allowing supervised contact of the adopted son may have been more appropriate option given the lack of an alleged perpetrator and the 4-year-old's significant history of abuse and possible sex abuse. Department procedures do not include a description or requirements for a "care plan," though it was used by the investigator in a way that made the parents feel they had no choice but to comply and abstain from contact. While the adopted son was returned to the parents after seven days following the VSI being deemed unnecessary, there was no substantive investigative activity completed for another 36 days. The foster parents were fearful of further trauma to their adopted son should they continue to foster the child. Their perceived discrimination and the unnecessary length of investigation played a significant role in the foster child being unable to return to their foster home, which consequently resulted in the loss of a valuable foster home.

RECOMMENDATIONS

1. The State Central Register should conduct normative sexual development training for all call floor workers and conduct a targeted 30-day review of all investigations taken for 22c, *Substantial Risk of Sexual Injury*.

The Department agrees. SCR Administration formalized normative sexual development training for all call floor workers and a "From the Classroom" training went out to all staff during team meetings in the month of September 2021. SCR Administrators and Supervisors will develop talking points for this practice refresher. These additional resources will also be used when training new staff. Additionally, SCR Deputy Administrators will conduct a targeted 30-day review of intakes which contain allegation #22c throughout the month of December 2021. If any deficiencies are noted, the intake will be discussed with the call floor worker and supervisor individually for training purposes.

2. The report should be redacted for use in training of call floor workers and child protection investigators.

The Department agrees. A redacted report will be used during the training of all call floor workers. The Office of Learning and Professional Development has been partnering with SCR on revisions to SCR Foundations and will incorporate this case into Foundations Training.

3. The Department should establish procedures for developing and monitoring care plans and for informing parents of their rights.

The Department agrees. Operations is in the process of collaborating with the Office of Legal Services regarding a formal response and guidance to the field.

4. This report should be shared with the involved foster care agency.

The Department agrees. The Inspector General provided a redacted report to the foster care agency.

5. In facility reports in which biological children are involved, the Department should modify procedures/SACWIS to allow Child Endangerment Risk Assessment Protocol to be conducted on the biological/adopted children.

The Department agrees. Child Protection will work with the State Central Register and the Office of Information Technology Services (OITS) to create functionality in SACWIS to permit the child protection investigator to complete a Child Endangerment Risk Assessment (CERAP) when there is a non-youth in care involved in any facility report. Once OITS creates this functionality we will incorporate the recommendation into Procedures 300, Appendix G, *Child Endangerment Risk Assessment*. In addition, this will be a requirement in SACWIS under the same timeframes and Report Management as all other CERAPs.

6. The Inspector General's Office will share this report with the Office of Affirmative Action for their review.

The Department agrees. The Inspector General provided a redacted report to the Office of Affirmative Action.

GENERAL INVESTIGATION 8

COMPLAINT

A child protection investigator engaged in solicitation of sex with a Department client who had a significant history with the Department as a minor and as an adult. The involved child protection investigator was the assigned investigator for multiple investigations involving the client and the client's family.

INVESTIGATION

OIG investigators found that the child protection investigator initiated a personal relationship, initially via Facebook messenger, at the same time that the client and her sister were alleged perpetrators in separate child protection investigations. The child protection investigator admitted to OIG investigators that he and the client initially messaged each other because the client was looking at a rental property that the child protection investigator owned. The messages progressed and he and the client began meeting in person. The child protection investigator bought the client dinner and drinks, gave her money, and eventually solicited her for pornographic photographs and sex. OIG investigators found no evidence that the interactions resulted in an actual physical, sexual relationship, as both the client and the child protection investigator said his solicitations were rebuffed. The Facebook messenger messages, however, showed that when his solicitations for sex were declined, the child protection investigator became angered and lashed out verbally.

While engaged in the personal relations with the client, the child protection investigator became actively involved in the child protection investigation of the sister when the supervisor requested assistance from the investigator in the removal of one of the sister's children. The child protection investigator failed to disclose his relationship with the family to his supervisor. When the child protection investigator arrived at the sister's home to take protective custody of the child, the family became upset and refused to turn over the minor. The woman the investigator had a personal relationship with was also at the sister's home. The family, knowing that the investigator had solicited the client for sex, unsuccessfully attempted to blackmail the child protection investigator in order to get him to steer placement decisions on the child taken into custody. Additionally, the

client and her sister told OIG investigators that they believed the Department took the sister's child into custody because the client refused the child protection investigator's advances.

After custody of the sister's children was taken, the child protection investigator continued to have contact with the client via text messages on both his Department-issued phone and his personal phone. Though the investigator was not assigned the case, the content of the messages were in reference to the sister's children, shelter care hearing, and their personal relationship. Additionally, after the child protection investigator learned of the OIG investigation into his conduct, the child protection investigator contacted the client to ask if she had spoken to OIG.

The child protection investigator displayed conduct unbecoming of a Department employee as he behaved inappropriately in seeking a sexual relationship with a client who had past and current involvement with the Department. The child protection investigator blurred the lines between acting in his professional capacity, a personal relationship, and a financial arrangement for sex. The child protection investigator did not disclose his relationship with the client to his supervisor even after being asked to assist in the removal of the sister's children, an action perceived by the family to be in retaliation for the client's refusal to engage in a sexual relationship. The child protection investigator created an environment of mistrust and perceived abuse of power in a role in which he was a representative of the Department.

RECOMMENDATIONS

1. The child protection investigator should be disciplined up to and including discharge for violations of Rule 437, *Employee Conflict of Interest*, and for conduct unbecoming of a state employee.

The Department agrees. The employee resigned.

2. The Office of the Inspector General will issue charges against the child protection investigator's Child Welfare Employee License.

Charges were issued and the licensee subsequently relinquished their Child Welfare Employee License.

GENERAL INVESTIGATION 9

COMPLAINT

A private agency caseworker did not conduct the required number of monthly visits with a medically specialized foster child, her SACWIS notes contained inconsistencies, and she failed to inform clients of their drug testing appointments, which caused the clients to miss those appointments.

INVESTIGATION

Pursuant to the private agency's contract with the Department, the private agency's caseworkers are required to visit in-person with specialized foster children at least three times a month, with at least two of those visits being in the foster home. The OIG investigation found that the private agency caseworker did not meet this requirement. The private agency's management must ensure that caseworkers have the support and resources to meet this requirement.

The private agency caseworker told her supervisor and OIG investigators that she made a mistake with a 2019 contact note and should have marked it as an attempted visit. Additionally, when OIG investigators interviewed the foster mother from the case, she was unable to recall the dates when the private agency caseworker visited

her home, and therefore, OIG investigators were unable to determine if the private agency caseworker intentionally falsified additional contact notes in 2019.

The private agency caseworker admitted to occasionally forgetting to notify parents of scheduled drug tests, but she did not include these missed tests in her court reports on the parents, so her error did not negatively impact the parents in court. As such, there was not enough evidence to show that the private agency caseworker displayed a "blatant disregard" of her duties as a child welfare employee when failing to notify individuals about their scheduled drug tests. However, the private agency caseworker did not follow the private agency agency's protocols that required caseworkers to document in SAWCIS when they make this mistake.

Although there is not enough evidence that the private agency caseworker committed blatant offenses in her role as a child welfare employee, OIG investigators did uncover additional errors on her part—such as inaccurate entries in her mileage reports and erroneous times listed in her SACWIS contact notes. These types of errors are more likely to occur if a caseworker is given a demanding caseload. At the time the errors occurred, the private agency caseworker had 15 children on her caseload, with five of them being specialized foster children. Due to the private agency's protocol, she was required to make three visits per month for each of these five children. It is difficult to accomplish these visits when they are located far from one another. Long driving times add to caseworkers' workload since the time they spend driving to visits is time that they cannot spend on their other duties.

Even though the private agency caseworker should have communicated that she was struggling with her workload, her supervisors also failed to recognize her struggles with a demanding caseload. Some workers are hesitant to ask for help or admit that they are falling short of expectations, because they are afraid they could be reprimanded. Proactive supervisors can create an environment of open communication from workers, anticipate difficulties, and offer assistance. Additionally, if supervisors and Agency Performance Team staff over-rely on the dashboard performance, it may unintentionally shift the workers' motivation. The dashboard is a helpful tool in monitoring private agencies' compliances with procedures, but agencies and Agency Performance Team staff cannot let the dashboard performance be the only factor. If agencies put too much pressure on their workers to meet the dashboard stipulations, then workers may feel pressure to become dishonest in order to reach the goals. Caseload crises may well lead to a triaging and focusing on one case more than another in any given month. The primary goal of a caseworker should be ensuring the wellbeing and safety of a child.

The private agency's protocol requires caseworkers to document in SACWIS when they forget to notify an individual about a scheduled drug test. The private agency caseworker admitted that she had forgotten to notify a parent on occasion, but in the three placement cases that OIG investigators reviewed, there were no notes in SACWIS to reflect when the private agency caseworker made this error. The private agency caseworker reported that she maintained the parents' drug testing information on digital files which can be problematic. SACWIS should be the primary tool that caseworkers use to record informing parents of drug tests. Considering that private agencies have been experiencing high turnover, and each of her placement cases had multiple caseworkers, failing to utilize SACWIS threatens to disrupt case information, allowing for the possibility of files to be lost in the turnover of employees.

RECOMMENDATIONS

1. A copy of this report should be shared with the private agency's management and its Agency Performance Team monitor for training purposes.

The Department agrees. OIG shared a redacted report with the private agency. The report was also shared with the Agency Performance Team monitor and supervisor.

2. The private agency's management should conduct a review of its specialized foster care cases to determine if the caseworkers are fulfilling the requirement to visit the youth three times a month. The private agency's management should provide the necessary resources and supports to ensure workers are able to meet this contractual requirement.

The Department agrees. The agency is currently completing weekly and monthly audits and giving workers scorecards that reflect their individual performance. This is done prior to when visits are due, to allow for a correction before a visit is missed - and after, to allow for trouble shooting and problem-solving during supervision. All workers were trained internally on new procedures. Agency Performance receives the scorecards and will continue to monitor the agency's quality improvement activities regarding this issue. In addition, the dashboard report indicates that monthly in-person caseworker contact with children has improved in the current fiscal year as compared to the prior year's performance.

3. The Department should review with the private agency's management the procedures of recording drug testing information into State Automated Child Welfare Information System, and then ensure that caseworkers are properly retrained on these procedures.

The Department agrees. The agency implemented an internal procedure to assist workers. All workers were trained internally and the agency's CQI (Continuous Quality Improvement) staff are tracking whether there is improvement. The Agency Performance Team monitor will continue to monitor the agency's quality improvement activities regarding this practice area. Further, the Department provided the agency with the IDCFS client drug testing protocol to review with staff which outlines the areas identified regarding documentation of substance abuse screen not completed at no fault of the parent.

GENERAL INVESTIGATION 10

COMPLAINT

A Department administrator assigned a day care licensing complaint investigation to the same field office that the subject, a Department employee, worked in. It was further alleged that the licensing supervisor, who oversaw the investigation, was a close friend of the subject and interfered with the licensing investigation by instructing the licensing representative investigating the complaint to refrain from interviewing the subject and to not conduct a home visit. When the licensing representative refused to complete the licensing complaint investigation without an interview or home visit, the licensing supervisor closed and unfounded the licensing complaint investigation.

INVESTIGATION

OIG determined that the day care licensing complaint investigation was assigned by a Department administrator to the same field office that the subject worked in. The licensing supervisor, who oversaw the licensing representative, shared an office wall with the subject and had a work-related friendship. Despite this relationship, the licensing supervisor did not believe the licensing complaint investigation was a conflict of interest and added that she did not believe the complaint against the subject had merit. OIG found that the licensing supervisor substantially limited the scope of the licensing complaint investigation, telling the licensing representative that she could not go to the subject's current address or interview her.

The licensing representative expressed her concerns regarding the supervisor's directive and asked that the investigation be transferred to another office, which the supervisor denied. The licensing representative conducted an investigation based on the limited scope as directed but refused to sign off on documentation stating that a full investigation had been completed. The licensing supervisor unfounded and closed the

investigation, circumventing the licensing representative. The Department administrator, who assigned the investigation, was notified of the licensing representative's concerns but failed to address them.

The OIG investigation concluded that assignment of a licensing compliant investigation of a Department employee to that employee's field office is an obvious conflict of interest and undermines public trust. As a result, an inadequate and unethical licensing complaint investigation was conducted. The supervisor interfered with the investigation by giving a directive to limit the scope of the investigation for reasons likely rooted in a work-related friendship between the subject and the supervisor and the supervisor's belief that the complaint was not legitimate. The licensing supervisor ignored the licensing representative's concerns and unfounded and closed the licensing complaint investigation without a complete investigation and proper paperwork. The Department administrator also failed to act on the licensing representative's reported concerns.

RECOMMENDATIONS

1. Department procedures should be amended to provide that licensing complaint investigations involving DCFS workers should be conducted by personnel from a different field office.

The Department agrees. Procedural changes were drafted and submitted to the Office of Child and Family Policy. Procedural changes will require that in the event a licensing complaint is made on a licensed or unlicensed day care facility involving a Department employee and/or their spouse, the receiving day care licensing supervisor shall immediately notify the Regional Day Care Licensing Administrator to facilitate reassignment of the stand-alone licensing complaint to another Region.

2. The Department administrator should be disciplined for failing to ensure the licensing complaint investigation of the unlicensed day care was adequately investigated and for failing to identify the conflict of interest when assigning the investigation to the same field office in which the subject worked.

The Department agrees. The employee received disciplinary counseling.

3. The licensing supervisor should be disciplined for inappropriately limiting the scope of the licensing complaint investigation of the unlicensed day care and for unfounding and closing an incomplete investigation.

The Department agrees. The employee was disciplined.

GENERAL INVESTIGATION 11

COMPLAINT

A Department employee, employed in the position of child protection investigator, made harassing and threatening phone calls to a mother and father who were the subjects of a pending child protection investigation, a case to which this employee was not assigned.

INVESTIGATION

A Hotline call came in alleging that a father was abusive to the mother and was using substances in the home with their four children, all under 13 years old. The father had a significant history with the Department and criminal convictions including a repeated history of drug use, domestic violence, gang activity, gun violence, assault, kidnaping and obstruction of justice.

OIG investigators found that prior to the Hotline call, the employee had both personal and professional relationships with the family. As a result of the prior personal relationship, the father reached out to the

employee requesting help in attaining drug treatment. The employee then aided the father in seeking drug rehabilitation by going to the mother and father's home and transporting the father to the drug treatment facility with her paramour in the car with her. The employee told OIG investigators that she took her boyfriend with her because the father was known to be violent. The employee asked her supervisor for the day off to do so.

After the father was dropped off at the facility, he immediately left the treatment center. The employee then called the mother. The mother reported to OIG investigators that the employee inexplicably blamed her for the father leaving treatment, accused her of using drugs, and threatened her by saying she is mandated reporter and could have her children taken away. The employee told OIG investigators that she did tell the mother she was a mandated reporter, but never threatened her. The employee said she was trying to convey to the mother she should not allow the father back in the home with the children. The employee could not recall if she told the mother that she could have the children taken from her. The employee admitted to OIG investigators that she was too emotionally invested in the outcome of this case given her history with the family.

A day later, the Hotline call came in for the child protection investigation on the mother and father. Both the assigned investigator and her supervisor reported they received multiple phone calls from the employee who said she feared for the safety of the assigned investigators who were to go to the family home and that the father was dangerous. She also told them that she had received phone calls from the father, who asked about the Hotline call. The supervisor advised the employee that the family would need to work with the assigned investigator and directed the employee not to have any further contact with the father.

Nine days following the Hotline call, and while the child protection investigation was pending, according to records obtained by OIG, the employee repeatedly called the mother between 12:30am and 3:00am. The mother reported that she picked up the phone around 2:30am and the employee made threats to the mother, accused the mother of coming to the employee's house, accused the mother of using drugs, and threatened to take her children. The employee told OIG investigators that prior to her calls to the mother, a strange male came to her home after midnight claiming to be a police officer and looking for the father. She said however that she recognized that he was not a police officer. The male reported he was going to go find the father. The employee reported that she was concerned that the man was dangerous and feared that the man may go to the family home. She said she was trying to warn the mother about the man. The employee acknowledged that during the phone call at 2:30 am, the mother was defensive, and emotions ran high. She admitted that she and her boyfriend made comments to the mother that were disparaging and regretted saying them. The employee also made multiple calls to the father. The employee acknowledged that she should have called the police instead of the family.

The mother contacted the police the following week and made a complaint about the harassing phone calls. The mother was granted a temporary no-contact order, but the order was voluntarily dismissed seven days later after an agreement in court that the employee would not have any further DCFS case involvement with the family.

OIG found that the employee displayed poor boundaries and blurred the lines between personal and professional relationships with Department clients. The employee repeatedly attempted to insert herself into the investigation out of seemingly sincere concern, however it was not found that she attempted to steer the investigation. The employee violated the supervisor's directive to abstain from contact with the family once the child protection investigation was initiated. The employee's inability to keep clear lines and repeated phone calls early in the morning resulted in the mother believing she was being harassed by the employee and that the employee was attempting to take her children.

RECOMMENDATIONS

1. The employee should be disciplined for her failure to follow her supervisor's directive not to contact the family.

The Department agrees. The employee was issued a written reprimand.

2. The employee should be referred to the Employee Assistance Program to address her boundary issues.

The Department agrees. The employee was referred to the Employee Assistance Program.

3. This report should be shared with the Area Administrator and the Regional Administrator for use in ongoing supervision.

The Department agrees. A redacted report was shared with the Area Administrator and the Regional Administrator.

GENERAL INVESTIGATION 12

COMPLAINT

A child protection investigator attempted to enter a hospital under the guise of conducting a child abuse/neglect investigation. The child protection investigator reportedly presented his DCFS badge to three different nurses and requested to see a 20-year-old patient. The child protection investigator reportedly returned a second time the hospital to accuse the head charge nurse of lying about him presenting his DCFS identification to hospital staff.

INVESTIGATION

Four hospital nurses and a security guard reported the child protection investigator and his companion presented to the emergency department. The child protection investigator was screened by emergency department nurses and escorted to the triage desk because he told staff he was with DCFS and needed to see a patient, showing staff his DCFS ID. After it was determined that the patient that he had requested to see was not a child and not a DCFS-involved patient, the child protection investigator was asked to leave. However, he returned about an hour later and became argumentative. Hospital staff reported the incidents to the local police and an incident report was generated. The OIG investigation found that it was the child protection investigator's girlfriend who accompanied him to the hospital, and it was the girlfriend's sister they were attempting to visit.

The child protection investigator, as an employee, is a representative of the Department when under his official capacity. The child protection investigator was not on duty and he inappropriately used his Department authority for personal reasons in an attempt to gain access to the hospital, giving the impression that he was representing the Department. When hospital personnel realized his misuse of authority and asked him to leave, he became hostile to staff. His conduct was not only unethical, but also unbecoming of the Department. Public displays of inappropriate authority can create mistrust amongst the community and further burden the mission of the Department.

Department investigators and specialists, when working in their professional capacity, have not been subject to hospital visitation restrictions, even during the COVID-19 pandemic. Department and private agency employees cannot abuse that power and use it for personal reasons as doing so may cause hospitals to place restrictions on Department workers leading to delays in investigative activities.

RECOMMENDATIONS

1. The child protection investigator should be disciplined for conduct unbecoming a DCFS employee including misusing his DCFS credentials and providing false statements during an OIG investigation.

The Department agrees. The Department has initiated the disciplinary process.

General Investigation 13

COMPLAINT A Department employee inappropriately used her Department position to circumvent a hospital's COVID-19 protocols in order to visit her new grandchild.

INVESTIGATION The OIG investigation found that the Department employee attempted to circumvent the hospital's COVID-19 protocol by implying she was at the hospital on official DCFS business. The worker's inappropriate actions created a general security risk for the hospital and due to the COVID-19 pandemic, a health risk for hospital staff and patients.

The hospital's COVID-19 protocols at the time allowed one designated support person in the maternity ward, which the mother of the baby had chosen. OIG investigators found that the employee had prior knowledge that there was another support person present, so the employee presented her DCFS ID and gave the impression to security, in two different locations of the hospital, that she was at the hospital on official Department business. The employee's actions enabled her to circumvent the hospital's COVID-19 protocol to gain access to the hospital for personal reasons. Once the employee arrived at the maternity ward, nursing staff were advised that the employee was not on official duty and the employee was asked to leave.

The employee's conduct was unethical and unbecoming of the Department. Public displays of inappropriate authority can create mistrust amongst the community and further burden the mission of the Department.

RECOMMENDATIONS **1. The employee should be disciplined for misuse of her Department authority and conduct unbecoming of the Department.**

The Department agrees. The Department has initiated the disciplinary process.

General Investigation 14

COMPLAINT Supervisors, employed by a private agency, violated policy when they accessed the State Automated Child Welfare Information System (SACWIS) and read the case record of a pending child protection investigation involving the private life of another employee, who was in their supervisory chain of command. The complaint further alleged that after viewing the pending investigation, one of the supervisors sent an email to the employee's direct supervisor and instructed her to speak with the employee and find out more details about the pending investigation. The complaint alleges that the supervisors misused SACWIS and violated the employee's privacy.

INVESTIGATION The private agency supervisors violated DCFS policy and procedures when they accessed SACWIS to search for the case record of a pending child protection investigation involving the private life of an employee. After being informed of the supervisors' actions, the Human Resources Director took immediate steps to educate the involved supervisors of their inappropriate use of SACWIS and has taken steps to educate and re-train all supervisors and staff on the proper use of SACWIS.

The Department's administrative rules and procedures take measures to protect the privacy and confidentiality of all persons served by DCFS, especially those cases that are pending and unresolved through a completed

child protection investigation. Specifically, when it comes to the SACWIS, where all pending investigations are stored, the Department has instituted Administrative Procedure #20, *Electronic Mail/Internet Usage/SACWIS Search Function*, to guide all DCFS and private agency staff on the authorized purpose and use of the SACWIS search function.

In this investigation, OIG found that three supervisors employed by the private agency violated DCFS policy and procedure when they accessed SACWIS to view and gain information about a child protection investigation that they knew was likely still pending. In this case, an employee complied with Department procedures and alerted her supervisor, albeit omitting all details, that DCFS had opened an investigation against her. The fact that the supervisors knew that the pending DCFS investigation was not related to the employee's work conduct should have caused the supervisors to pause and report what they had learned to the agency's human resources department before taking any further action.

On interview, OIG found credible the supervisors' independent accounts that they searched SACWIS to confirm whether there was in fact a pending investigation against one of their supervisees and did not know that such a search was prohibited by DCFS Administrative Procedure 20, *Electronic Mail/Internet Usage*, as they had never encountered this type of situation before and had never received training on the appropriate use of SACWIS. OIG concluded that the supervisors did not act with malintent or malfeasance, rather their lack of education and training on how to handle this type of self-report and the appropriate use of SACWIS led to the supervisors' actions.

When interviewed by OIG, private agency management acknowledged that although the supervisors' actions violated DCFS policy and procedure, all three supervisors were relatively new supervisors and it was believable that none of the involved supervisors had ever encountered this type of disclosure previously. The Human Resources Director acknowledged that all supervisors needed to be educated and retrained on the appropriate use of SACWIS. The private agency demonstrated to OIG that they have taken specific actions to educate and re-train all staff on the appropriate use of SACWIS in order to prevent future misuse.

Because OIG found that the supervisors did not act with malfeasance or malintent, OIG did not make any recommendation for individual or agency corrective action.

RECOMMENDATIONS

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

The Department agrees. The Inspector General shared the report with the private agency.

APPENDIX

BAXTER DARBY A-1
BELLA CASTILLO ESPARZA B-1

APPENDIX A

OFFICE OF THE INSPECTOR GENERAL

Department of Children and Family Services

REDACTED REPORT

This report is being released by the Office of the Inspector General for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names, except those of professional references, are fictitious.

File No: **2020-IG-1131**

Subject: **Anna Darby, Adoptive parent**

Child: **Baxter Darby, Adopted child**

SUMMARY OF COMPLAINT

The Office of the Inspector General ("OIG") of the Department of Children and Family Services ("DCFS" or "Department") received a complaint relating to adoptive parent, Anna Darby, and her son, Baxter Darby[1], a multi/special needs child. A 2006 adoption assistance agreement allowed for Ms. Darby's mother, Chloe Emerson, to provide therapeutic day care for Baxter on a daily, weekly, and yearly basis to be paid for by the Department.[2] However, the complaint alleged that Ms. Darby submitted requests for payment for therapeutic day care services outside the customary process and for services not actually provided.

It was further alleged that when DCFS staff spoke to Ms. Darby about the continued therapeutic day care for her teenaged son, Ms. Darby reported that she had been told by DCFS staff members, in previous years, to continue submitting requests for day care reimbursements even though Ms. Emerson was no longer providing the service, as Ms. Darby's subsidy under the adoption assistance agreement was at the maximum amount, and the day care payment would serve as an increase to the subsidy payment.

FINDINGS

Ms. Darby regularly submitted requests for reimbursement like those in Appendix A (attached), which purport to represent: 1) the dates on which therapeutic day care services were provided for Baxter; 2) the hours per day those services were provided; 3) the amount of money the provider charged Ms. Darby for those services; and 4) the amount of money Ms. Darby paid out of pocket to the provider, for which she sought reimbursement from the Department. For many of the reimbursement requests Ms. Darby submitted to the Department over the years, each and every one of those four representations was false. Nevertheless, the Department paid Ms. Darby the reimbursements requested. Thus, Ms. Darby fraudulently obtained thousands of dollars of therapeutic day care reimbursement payments from the Department.

OIG is not certain from our interviews and the available documentary evidence precisely which of the reimbursements Ms. Darby received over the years were fraudulent. Indeed, some reimbursements were

[1] In 2006, Ms. Darby adopted Fabian Galloway and changed his name to Baxter Darby.
[2] Ms. Darby would pay her mother and then submit requests for reimbursement.

legitimate. OIG is most certain, however, about the reimbursements Ms. Darby received during the summers of 2018 and 2019. During those summers, Baxter was employed with Ms. Darby at a government office, and Ms. Darby received reimbursements for full-day day care services on days that payroll records show Baxter was at work.

Ms. Darby readily acknowledged to OIG investigators that she billed the Department and received reimbursements for day care services even after her mother had stopped providing the service. In short, Ms. Darby has acknowledged the fraud. She claimed that she did so with the full knowledge and consent of DCFS staff members due to the fact that the subsidy payments she had been receiving under her adoption assistance agreement were insufficient to cover Baxter's care and needs. OIG investigators were unable to determine definitively that specific DCFS staff members explicitly told or even actively allowed Ms. Darby to continue submitting requests for therapeutic day care solely as an increase of her subsidy. OIG investigators did find that staff members[3] had allowed Ms. Darby to circumvent usual practices in submitting and processing requests for payment. The current adoption worker, Mika Livingston, and the worker just prior to her, Graham Pace, reported that they believed Ms. Darby's mother was providing therapeutic day care. Thus, they acted in the way that their predecessors had, that is, they received the payment requests directly and referred them to the vouchering unit for payment, which was not DCFS's usual practice.

INVESTIGATION

Background

At the time of Baxter's birth, his biological mother, Sasha Galloway, had a prior history with the Department. In September 1993, the Department indicated Ms. Galloway for inadequate supervision and environmental neglect of her five children. Following her violation of an order of protection during an open intact family case, the Department brought the children into care in May 1994, placing them with the maternal grandmother, Tiffany Galloway. The children were adopted in 1998. Two subsequent children, born in January 1996 and September 1997, also were taken into care.[4] Those children were adopted in 1999 and 2003, respectively. In October 2001, Ms. Galloway gave birth to twin boys, Vance and Fabian Galloway.

At the time of birth, the twins tested positive for cocaine. DCFS initiated an investigation for allegation #65 substance misuse. According to DCFS's records, Ms. Galloway admitted to smoking cocaine throughout her pregnancy, had not sought prenatal care, and did not want to participate in drug treatment. The twins weighed only 2 pounds, 11 ounces each; doctors noted several life-threatening conditions. Less than three weeks later, Vance died from a bowel obstruction.

Fabian continued to struggle with illness. Doctors diagnosed a heart murmur, neutropenia, lymphopenia, and reactive airway disease at birth. During his time in the hospital, he was also diagnosed with failure to thrive, retinopathy of prematurity, and necrotizing enterocolitis. He eventually gained strength, and doctors determined he could be discharged. After less than a week stay with a relative, Fabian was placed at the Lovelace Center for Medically Complex Children. Once stabilized, a specialized foster home was sought. On December 21, 2001, Fabian was placed with William and Anna Darby, a non-relative specialized foster home.

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[3] Heidi Forrest, Office Administrator; Izabella Garcia, Supervisor; Josephine Hahn, Account Tech; Kyra Ingles, Supervisor; Lucy Jackson, Clerical Staff Supervisor; Mika Livingston, Post Adoption Caseworker; Nova Manjarrez, Post Adoption Unit Supervisor; Ophelia Navarro, Administrative Assistant; Poppy Owens, Office Administrator; Graham Pace, Post Adoption Unit Caseworker.

[4] The Department indicated the mother for substantial risk of harm in 1996; the Department indicated the mother for substance misuse in 1997, after the newborn baby tested positive for cocaine.

In May 2002, Fabian was diagnosed with severe immune system compromising illness leaving him highly susceptible to illnesses. In August 2002, Ms. Galloway signed final and irrevocable consent forms agreeing to the Darbys adopting her son, Fabian. The Darbys adopted Fabian in 2006 and officially changed his name to Baxter Darby.

Adoption Assistance Agreement
OIG investigators reviewed the adoption assistance agreement between the Department and the Darbys signed in June 2006. The agreement determined the subsidy and other post-adoption costs that the Department would cover and Medicaid coverage for the adoptee.

The agreement delineated Baxter's medical conditions and needs, most significantly his immune system illness, but also respiratory and cardiac issues. The agreement noted that the reactive airway disease symptoms could be better managed by avoiding allergen triggers through airduct cleaning twice yearly and carpet cleaning four times a year. Treatment for the immune system illness, often not covered by Medicaid, included monthly intravenous immunoglobulin (IVIG) replacement therapy and pergolated adagen (PEG-ADA). Possible future treatments that were listed was gene therapy and bone marrow/stem cell transplant.

The agreement listed the services Baxter was receiving at the time of adoption (some not covered by Medicaid) with the request for continued coverage:

- Monthly visits with an immunologist
- Primary care physician visits at least every three months and as needed
- Monthly IVIG treatment with a medical work-up prior to treatments
- Twice weekly PEG-ADA injections (and a mini refrigerator for storage of medication)
- Home nursing services to administer injections on an as-needed basis
- Annual flu vaccines
- Annual chest x-rays to evaluate possible asymptomatic lung disease progression
- Twice yearly visits to an out-of-state specialist at Fibonacci Children's Hospital Medical Center (the agreement named other specialists that could be substituted in) with travel and lodging also covered
- Family attendance, annually, to at least one Immune Deficiency Foundation Family Retreat – the cost of the conference, air travel, lodging and child care to be covered
- Quarterly dental cleanings and prophylactic treatments with the balance not covered by Medicaid to be covered by the Department
- Yearly ophthalmologist visits as needed
- Therapeutic daycare
- School district homebound program
- Small group socialization classes
- Twice yearly airduct cleaning
- Four times a year carpet cleaning
- Oscillating pedestal heater
- 12-gallon humidifier
- 45-pint dehumidifier
- Oscillating table fan
- Air purifier

The agreement also listed possible immune system illness future needs/treatments to be covered by the Department. These included:

- Bone marrow/stem cell treatment and/or gene therapy should it be needed
- In-home therapeutic services
- Treatment of optical fungal infections
- Orthodontics
- Cost of travel to out-of-state medical facilities
- Expense of attending school in a small classroom setting in the event that the local school system is unable or unwilling to cover
- Hospice care
- Respite care – the agreement noted that respite care may be needed, to be provided by the Division for Specialized Care for Children (DSCC) and the Darbys must apply for DCSS should Baxter become more "medically fragile/technology dependent in order to determine eligibility for this service."

The monthly cash subsidy in the agreement was $1,502, or $18,024 annually. On the subject of therapeutic day care, the agreement specified, "Chloe Emerson has provided therapeutic day care services to the family since 2002. She has been trained by medical staff on the proper storage and administration of Baxter's medications and she is familiar with his education needs. The number of service hours provided varies with the need."

Current Situation

Baxter graduated from Demeter High School in Spring 2020.[5] Ms. Darby is employed by a government office. Baxter worked for the same government office as a student worker during the summers of 2018 and 2019.

In February 2020, Ms. Darby began submitting requests for therapeutic day care with a new provider other than Ms. Emerson. Xandra Quinn, senior management at the Statewide Program, reported that the request was partially denied as Ms. Darby reported she had a provider coming to the home for an hour to clean before the provider picked up Baxter from school. Ms. Quinn told OIG investigators she would not approve paying someone when Baxter was not at the house.

When Ms. Darby learned that the case had been referred to OIG, she called OIG and spoke with the OIG investigator assigned to the case. Ms. Darby reported that she and her husband had taken Baxter in when he was 6 weeks old and had been told Baxter was born on the streets. Ms. Darby described her son's medical issues as Baxter having no immune system, a kidney with fatty deposits, high blood pressure, ADHD, low lipid cells from being exposed to, but negative for, HIV. She reported that Baxter requires gene therapy[6] infusions every two weeks and multiple extensive doctor visits. She added that in 2009, doctors found seven tumors on Baxter's back. After biopsy, two tumors were determined to be malignant and Baxter required chemotherapy. Ms. Darby said the other tumors continue to be monitored. Baxter regularly takes at least seven different types of medication, has a personal trainer, and needs a nurse.

Ms. Darby stated that previously, assigned adoption workers had assisted her with being able to provide for Baxter's extensive needs. Ms. Darby stated, "My mother, Chloe Emerson, who is 87 years old, was providing the therapeutic day care because of the immune deficiency and Baxter could not go out. I was paying my mother, who was approved by the State, and then I was reimbursed." Ms. Darby reported, however, that her mother had not recently been caring for Baxter even though she continued requesting and receiving reimbursements. She explained that the $1,502 subsidy payment does not cover the cost of Baxter's daily care and she has never had an increase. She added that, "over the years, there have been many

[5] Demeter High School is a private school.
[6] Ms. Darby reported this involves traveling to the headquarters of the National Institute of Health.

DCFS case workers assigned to Baxter, some have retired, and the current worker, Mika Livingston, knew about the therapeutic day care. Each caseworker just continued with the case." She also reported that she had recently not been submitting for reimbursement for certain services covered by DCFS, including carpet cleaning and attending conferences.

Extension of Services
Adoption Unit Supervisor Nova Manjarrez reported to OIG investigators that the Department recently extended the subsidy and service for Baxter beyond his 18th birthday as requested by Ms. Darby.

Therapeutic Day care Reimbursement Requests
After adopting Baxter in 2006, Ms. Darby appeared to consistently bill for therapeutic day care for all but four or five days per month.[7] She generally submitted requests for reimbursement of approximately $2,400 a month, and occasionally more.[8]

Yolanda Ramsey, Administrative Assistant, reported that in September 2019, she received payment requests for therapeutic day care submitted by Ms. Darby. This was the first time Ms. Ramsey had received any such request. Ms. Ramsey explained to OIG investigators that she is supposed to receive all therapeutic day care payment requests; she checks for documentation and, if supported, signs off and sends the request to Administrator Izabella Garcia. Ms. Garcia, upon approval, sends the request to the vouchering unit to issue payment. Ms. Ramsey determined that Ms. Darby had been submitting the payment requests directly to Caseworker Livingston, who then forwarded the requests to vouchering for payment. Ms. Ramsey reported that she did not know how long the circumvention had been occurring. At the time Ms. Ramsey received the payment request in August 2019, Ms. Livingston was out on a brief medical leave. In the past, the assigned adoption worker would send the invoice to the business office for creation of a payment slip. With the adoption worker out, the invoice was sent to Ms. Ramsey.

Ms. Ramsey told OIG investigators that upon receiving the request in late August 2019, she noted that Ms. Darby sought reimbursement for paying her mother for therapeutic day care, but the payment request did not have paperwork to validate the care provided. On September 13, 2019, Ms. Ramsey requested a teleconference with Ms. Darby, Ms. Livingston, and the covering supervisor, Kyra Ingles. Ms. Ramsey told OIG investigators, "Ms. Darby started name dropping DCFS employees who are now retired, who told her to keep billing for therapeutic day care, even though Ms. Emerson was no longer providing the service." Ms. Ramsey said Ms. Darby reported prior workers had told her she could not receive an increase in subsidy payments, as her subsidy was at the highest rate, so the therapeutic day care payments would act as an increase of the subsidy payments. Ms. Ramsey said the group noted that Ms. Darby was billing for 109 hours of care every two weeks even though Baxter is a high school senior. Ms. Ramsey stated that as the teleconference ended, Ms. Darby was told that she would not be paid for the therapeutic day care and "Ms. Darby did not like that."

Adoption Supervisor Ingles confirmed to OIG investigators that Ms. Ramsey called for a teleconference on September 13, 2019. Ms. Ingles filled in on the call for Ms. Livingston's supervisor, Ms. Manjarrez, who was not at work that day. Ms. Ingles recalled that Ms. Ramsey requested documentation for the day care or some other service, possibly, respite care. According to Ms. Ingles, Ms. Darby said she understood the request, but reported that her mother was no longer providing care. Ms. Darby stated, "it was part of the payment- paid as part of the subsidy. Zoey Schmitt [former worker] knew about it. It has been going on for a long time." Ms. Ingles said that the worker, Ms. Livingston, did not appear to know that was the case.

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[7] OIG investigators asked the vouchering unit for all past invoices submitted, but the vouchering unit did not have that paperwork. OIG investigators found some invoice and payment requests in the file, but many months were missing.
[8] Though some of the invoices Ms. Darby submitted could not be located, the payment unit was able to determine payments made to Ms. Darby using her provider ID.

Ms. Darby was informed on the teleconference that Ms. Ramsey would have to check with the prior worker, Graham Pace, and with Ms. Manjarrez.

Ms. Manjarrez told OIG investigators the Darby case had a problem with processing payment once Placement Specialist Ophelia Navarro left the unit. Ms. Manjarrez explained that she has been a post-adoption supervisor for three years, supervising two post-adoption workers[9] and three clerical workers.[10] When Ms. Navarro worked for Ms. Manjarrez, Ms. Navarro, unbeknownst to Ms. Manjarrez, had the ability to create the "buck slip."[11] Her current clerical staff cannot create a buck slip, and so when Ms. Darby submitted her request to the unit after Ms. Navarro had left, and Ms. Livingston was not there, Ms. Manjarrez took the payment request to Ms. Ramsey. In the past, Ms. Livingston would process the bill and give it to Ms. Navarro, who would submit it straight to the business unit. Ms. Manjarrez reported that Ms. Ingles told her about the phone conference. Ms. Manjarrez told OIG investigators she was not aware of any other adoption case receiving therapeutic day care.

Current adoption worker, Ms. Livingston, told OIG investigators that the prior adoption worker, Mr. Pace, had informed her that Ms. Darby would fax invoices for therapeutic day care services twice a month, and they would go to the post-adoption clerical worker. Ms. Livingston said she did not review or question the invoices and did not approve a buck slip, as that was the prerogative of the payment unit. Ms. Livingston specified that subsidy-related requests are handled by the clerical team, and service-related requests, such as counseling, go to Ms. Ramsey. She indicated this was the only case where the adoptive parent would send her invoices for therapeutic day care; others on her caseload received the subsidy for therapeutic day care, but she did not see those invoices and was not sure where they are sent.

Ms. Livingston confirmed that a teleconference took place in which Ms. Ramsey told Ms. Darby she would need to provide additional documentation before being paid. Ms. Darby then told the group that she had been providing the therapeutic day care herself, though did not specify an exact timeframe. Ms. Ramsey told Ms. Darby she could not provide the day care herself. In response Ms. Darby talked about caring for Baxter's extensive health needs and involvement with the Department, and she alluded to many prior workers knowing about the service. At the conclusion of the teleconference, Ms. Darby was told that she would not be paid for the therapeutic day care and would have to re-apply.[12]

OIG investigators spoke with the previously assigned worker, Mr. Pace.[13] Mr. Pace told OIG investigators that a prior worker, Courtney Valentine, and another previous caseworker, whose name he could not recall, told him that the Darby case was a priority case. They explained that Baxter has several special needs requiring therapeutic day care, which was included in the subsidy. Ms. Darby would pay her mother, who had been trained, and the Department reimbursed her. Ms. Darby would, twice a month, fax a generic form indicating dates and hours of therapeutic day care provided. Mr. Pace would then review the request and give it to one of the support staff (usually Poppy Owens or Ms. Navarro, clerical workers with seniority), and send an email to the business office. He reported Ms. Darby would call him when there was a lag in payment. Mr. Pace reported that he had no other cases for which he received therapeutic day care payment requests. Other requests go to the Statewide Adoption Monitor Unit to work out the payment. Mr. Pace did not know why this was not the case for Ms. Darby.

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[9] Graham Pace and Mika Livingston.

[10] Two readers (clerks who review adoption subsidies), Alexa Thornton, Brenna Underwood and office coordinator Lucy Jackson take care of filing, mailing correspondence, entering documents, and case openings.

[11] The "buck slip" is the term used for the official request for payment slips sent to the payment unit. Only certain employees are allowed to create the slips. Ms. Ramsey is the worker who is authorized to create the slips for post adoption.

[12] Ms. Livingston reported that she had sent the necessary forms to Ms. Darby.

[13] Mr. Pace has been with the post adoption unit for seven years and 15 years working with adoptions.

Former office specialist, Ms. Navarro, told OIG investigators that when working in the post-adoption unit, she was responsible for registering cases, assigning cases to workers, and filing case forms. Ms. Navarro said Ms. Darby would fax payment requests to Ms. Livingston and Mr. Pace usually twice a month. The payment request would then be taken to the vouchering unit on the 6th floor. Normally, a payment request would not be processed through the adoption unit; the Darby case was the only exception. Ms. Navarro's former supervisor in the post-adoption unit, Lucy Jackson, told OIG investigators that she did not know that Ms. Navarro, who had been in the unit longer than Ms. Jackson, was creating the payment slips for Ms. Darby. She reported no other adoptive parents send therapeutic day care slips through the post-adoption unit.

OIG investigators then spoke to Office Manager Heidi Forrest.[14] According to Ms. Forrest, Ms. Darby would call almost every month to ask how long before her request was processed. Usually, Ms. Navarro from the post-adoption unit would bring the buck slip to them. Ms. Forrest said she just assumed that everything was approved, as that is the way it was always done for this case.

Review of the Adoption File

OIG investigators obtained the hard-copy adoption file. The file contained the adoption assistance agreement, paperwork related to the agreement, assessment records that predated the adoption, and supporting documents. Invoices for reimbursement of therapeutic day care, faxed to the adoption worker by Ms. Darby, were mixed in. Also, receipts for services that were listed as covered by the subsidy, such as carpet cleaning and travel, were found. After making a copy, an OIG investigator organized the file by fiscal year. The number of invoices varied by fiscal year. The invoices contained typed-out dates, hours of therapeutic day care reportedly provided by Ms. Emerson, and the total amount for which Ms. Darby was requesting reimbursement. The adoption file also contained a handwritten note indicating that Ms. Darby was seeking to pay herself for therapeutic day care while she took her son to the National Institute of Health for experimental treatment, which required them to stay out of state for a number of months.[15]

Payment Unit Data

The payment unit was not able to provide any original invoices Ms. Darby sent for reimbursement of therapeutic day care costs, but the Office of Budget and Finance provided information to OIG investigators on payments to Ms. Darby, based on her provider ID, from FY 09 through FY 18. OIG investigators took the amount of money paid, subtracting the subsidy amount and other miscellaneous payments, to approximate the amount of money paid to Ms. Darby for therapeutic day care.

[14] Ms. Forrest has been in this position for 22 months. Previously, the position was held by Ms. Schmitt, who retired two years ago. Ms. Forrest supervises six account techs and one accountant.

[15] Ms. Darby took FMLA from her job for the purpose of taking her son for experimental treatment at NIH.

Fiscal Year	# of invoices found in adoption file	Money paid to Ms. Darby (not including monthly subsidy and miscellaneous payments)
FY 07	18	Not available
FY 08	24	Not available
FY 09	24	$29,607
FY 10	1	$39,607
FY 11	None found	$31,140
FY 12	None found	$30,000
FY 13	None found	$29,870
FY 14	5	$29,892
FY 15	5	$29,784
FY 16	22	$31,356
FY 17	22	$31,308
FY 18	21	$30,984

Ms. Darby's Government Employment

Ms. Darby has worked for the same government office for over 15 years. According to that office, Ms. Darby used Family Medical Leave Act time to care for her son. Ms. Darby reported paying herself for therapeutic day care when using FMLA time for a six-month period, from November 2009 to May 2010, when she took Baxter to the National Institute of Health for experimental treatment. From May 2013 to May 2014, she used FMLA time sporadically, two to five days per week for medical appointments and treatment. From September 2014 through February 2015, she reported the need for sporadic FMLA time, one day per week for infusions, quarterly doctor visits, and twice-yearly NIH visits. From May 2015 to May 2016, the requested sporadic FMLA was for doctor appointments up to two times a week, and for four-day visits to NIH every two months. The May 2016 to 2017 request included the NIH appointments as well as weekly infusions; the 2017 to 2018 and 2019 requests were similar.

From March 17 to May 31, 2020, Ms. Darby was on work-from-home status with the government office. According to an investigator with that government office, this meant that Ms. Darby was expected to keep abreast of her emails and be available to be called in on 24 hours' notice.

Baxter's Government Employment

Baxter worked for the same government office as a student worker during the summers of 2018 and 2019. OIG investigators obtained Baxter's employment records, including the dates and hours Baxter worked. According to those employment records, Baxter performed general supportive duties "including filing, xeroxing, answering telephones, opening mail and other routine functions."[16] In comparing the records with invoices submitted by Ms. Darby, OIG investigators found that on days Baxter worked, Ms. Darby also sought reimbursement for monies she allegedly paid out for therapeutic day care. (See Appendix A).

ANALYSIS

Ms. Darby appears to be a loving mother, dedicated caretaker, and strong advocate for her son. She consistently sought out treatments and opportunities for her son, assuring that DCFS provides all possible assistance benefits. That being said, Ms. Darby sought reimbursement payments for at least some therapeutic day care services she never received (and thus never paid for out of pocket).

[16] Baxter was paid $12 an hour in 2018 and $13 an hour in 2019.

Some of the reimbursement payments made by DCFS to Ms. Darby likely were legitimate. After all, Ms. Emerson, the provider in question, is an approved and trained therapeutic day care provider. Also, the adoption assistance agreement stated that Baxter was receiving therapeutic day care at the time of the adoption and recommended that those services continue post adoption. Thus, it is reasonable to give Ms. Darby the benefit of the doubt as to reimbursements where there is no proof of illegitimacy. Obviously, legitimate reimbursements owed to Ms. Darby do not lose legitimacy or somehow become fraudulent solely due to DCFS employees' failure to follow DCFS's normal vouchering protocols.

However, there is no dispute that at least some of the reimbursement requests were fraudulent. By Ms. Darby's own admission, she continued to submit reimbursement requests and receive reimbursement payments after her mother stopped providing the service, purportedly with the blessing of certain DCFS employees.

The question is: Which reimbursement requests and payments did OIG uncover for which there is any proof of illegitimacy? The answer is found in the chart created by the OIG at Appendix A. The OIG found 55 days during the summers of 2018 and 2019: 1) on which the government office's employment records show that Baxter worked; *and* 2) for which Ms. Darby represented that Baxter received therapeutic day care services and that she paid Ms. Emerson for those services. As the chart shows, for all but a handful of those 55 days, Baxter worked a state employee's full day (7.5 hours) while also supposedly receiving nine hours of day care. Based on the $12 per hour rate purportedly charged by Ms. Emerson, and the total of 483 hours of services she purportedly provided on those 55 days, Ms. Darby requested and received $5,796 (483 hours x $12 per hour) in reimbursements for which there appears to be proof of illegitimacy.

Clearly, the Department should not have paid for a full day of therapeutic day care for Baxter while the state also was paying him for a full day's work. A state employee may need reasonable accommodations or may require extra care in which a caretaker may be needed and still be able to perform his/her job. However, Ms. Darby sought reimbursement for therapeutic day care, not for care related to enhancing independence.

The State of Illinois provides a monthly subsidy to eligible adoptive parents. Adoption agreements often provide for payment for other services the child may need. In this case, therapeutic day care was included. Baxter was 4 years old at the time of his adoption and there was a clear need for the service. What becomes more questionable, though, is the need for the service as Baxter aged, as his mother was submitting invoices because she felt that she needed the money and not because she was using the day care.

Though the question of the appropriateness of the day care service arose, OIG investigators did not determine whether therapeutic day care is a service that Baxter still needs. That should be determined by a review conducted through DCFS Clinical, the DCFS Medical Director, and the Division of Nursing. As Ms. Darby reported that she is providing care in the home herself, and Baxter is now 19 years old, there is a possibility she could be paid through the Medicaid program which pays family members as caregivers.

This investigation does not seek to diminish the care that Mr. and Ms. Darby have provided to Baxter. However, another problem lies in the way in which Ms. Darby was able to circumvent the usual system. DCFS workers interviewed readily acknowledged they continued the practice because it had "always been done that way." Baxter has had seven workers assigned to his adoption case over the years. OIG investigators were not able to interview all of the prior workers. While it is important that a Department which serves children and families of various needs not be so rigid as to make getting needed services difficult and bureaucratic, a general structure is needed to serve all families. OIG is not recommending any changes to the Department's vouchering structure and protocol, however. The failure in this case appears to be that the normal protocol simply was not followed.

Finally, OIG takes no position and makes no recommendation regarding how, or even whether, DCFS should seek some measure of relief from Ms. Darby relating to the fraudulent reimbursement requests and payments.

RECOMMENDATIONS

1. The Inspector General will refer this report to the Illinois State Police for evaluation of possible criminal fraud by Ms. Darby.

2. The Inspector General will share this report with the Office of the Inspector General for the government office that employs Ms. Darby.

3. Baxter Darby's case should be reviewed by the DCFS Medical Director, a representative from the Division of Nursing, a representative from DCFS Clinical, and a representative of Illini Care to determine what are the needed services for Baxter that can be adequately addressed through the provisions of the subsidy and Medicaid Managed Care Services.

Appendix A: Table (created by OIG) and Copies of Invoices Submitted by Anna Darby

Baxter's Government Employment Dates and TDC Reimbursement Request

Summer 2018 Dates	# Hours Worked	# of Hours TDC Reimbursement Request	Summer 2019 Dates	# Hours Worked	# of Hours TDC Reimbursement Request
June 2018			**June 2019**		
13	7.5	9	3	7.5	9
14	7.5	9	4	7.5	9
15	7.5	9	5	7.5	9
July 2018			6	7.5	9
2	7.5	9	7	7.5	9
3	7.5	9	10	7.5	9
5	7.5	9	11	7.5	9
6	7.5	9	12	7.5	9
9	7.5	9	13	7.5	9
10	7.5	9	14	7.5	9
11	7.5	9	17	7.5	9
12	6.0	9	18	7.5	9
13	7.5	9	19	7.5	9
16	7.5	9	24	7.5	9
17	5.5	9	25	7.5	9
18	7.5	9	26	7.5	9
19	7.5	9	27	7.5	9
20	7.5	9	28	7.5	9
23	7.5	9	**July 2019**		
24	7.5	9	1	7.5	5
25	7.5	9	2	7.5	9
26	7.5	9	3	7.5	9
27	5.0	9	5	7.25	9
			8	7.0	5
			9	7.5	9
			10	7.5	9
			11	7.5	9
			12	7.5	9
			15	7.5	5
			16	3.75	9
			23	7.5	9
			24	7.5	9
			25	7.5	9
			26	7.5	9

Aug 2019 02:50PM HP Fax page 3

, Illinois

Therapeutic Day Care

Child	Case ID	Service Dates	Hours	Rate	Total
		07/16/2019	9		
		07/17/2019	9		
		07/18/2019	9		
		07/19/2019	9		
		07/21/2019	5		
		07/22/2019	9		
		07/23/2019	9		
		07/24/2019	9		
		07/25/2019	9		
		07/26/2019	9		
		07/28/2019	5		
		07/29/2019	9		
		07/30/2019	9		
		07/31/2019	9		
Grand Total			118	12.00	1,416.00

Received Payment Mrs. $1,416.00 Signature of Provider

Aug 2019 02:50PM HP Fax page 3

, Illinois

Therapeutic Day Care

Child	Case ID	Service Dates	Hours	Rate	Total
		07/16/2019	9		
		07/17/2019	9		
		07/18/2019	9		
		07/19/2019	9		
		07/21/2019	5		
		07/22/2019	9		
		07/23/2019	9		
		07/24/2019	9		
		07/25/2019	9		
		07/26/2019	9		
		07/28/2019	5		
		07/29/2019	9		
		07/30/2019	9		
		07/31/2019	9		
Grand Total			118	12.00	1,416.00

Received Payment Mrs. $1,416.00 Signature of Provider

, Illinois

Therapeutic Day Care Child	Case ID	Service Dates	Hours	Rate	Total
		07/16/2018	9		
		07/17/2018	9		
		07/18/2018	9		
		07/19/2018	9		
		07/20/2018	9		
		07/22/2018	5		
		07/23/2018	9		
		07/24/2018	9		
		07/25/2018	9		
		07/26/2018	9		
		07/27/2018	9		
		07/29/2018	5		
		07/30/2018	9		
		07/31/2018	9		
Grand Total			118	12.00	1,416.00

Received Payment $1,416.00 Signature of Provider_

Aug 2019 02:50PM HP Fax page 3

, Illinois

Therapeutic Day Care Child	Case ID	Service Dates	Hours	Rate	Total
		07/16/2019	9		
		07/17/2019	9		
		07/18/2019	9		
		07/19/2019	9		
		07/21/2019	5		
		07/22/2019	9		
		07/23/2019	9		
		07/24/2019	9		
		07/25/2019	9		
		07/26/2019	9		
		07/28/2019	5		
		07/29/2019	9		
		07/30/2019	9		
		07/31/2019	9		
Grand Total			118	12.00	1,416.00

Received Payment $1,416.00 Signature of Provider_

, Illinois

Therapeutic Day Care

Child	Case ID	Service Dates	Hours	Rate	Total
		07/16/2019	9		
		07/17/2019	9		
		07/18/2019	9		
		07/19/2019	9		
		07/21/2019	5		
		07/22/2019	9		
		07/23/2019	9		
		07/24/2019	9		
		07/25/2019	9		
		07/26/2019	9		
		07/28/2019	5		
		07/29/2019	9		
		07/30/2019	9		
		07/31/2019	9		
Grand Total			118	12.00	1,416.00

Received Payment Mrs. $1,416.00 Signature of Provider_

, Illinois

Therapeutic Day Care

Child	Case ID	Service Dates	Hours	Rate	Total
		06/02/2019	5		
		06/03/2019	9		
		06/04/2019	9		
		06/05/2019	9		
		06/06/2019	9		
		06/07/2019	9		
		06/09/2019	5		
		06/10/2019	9		
		06/11/2019	9		
		06/12/2019	9		
		06/13/2019	9		
		06/14/2019	9		
Grand Total			100	12.00	1,200.00

Received Payment Mrs. $,200.00 Signature of Provider_

, Illinois

Therapeutic Day Care

Child	Case ID	Service Dates	Hours	Rate	Total
		6/16/2019	5		
		6/17/2019	9		
		6/18/2019	9		
		6/19/2019	9		
		6/20/2019	9		
		6/21/2019	9		
		6/23/2019	5		
		6/24/2019	9		
		6/25/2019	9		
		6/26/2019	9		
		6/27/2019	9		
		6/28/2019	9		
		6/30/2019	5		
Grand Total			105	12.00	1,260.00

Received Payment Mrs. $1,260.00 Signature of Provider

, Illinois

Therapeutic Day Care

Child	Case ID	Service Dates	Hours	Rate	Total
		07/01/2019	9		
		07/02/2019	9		
		07/03/2019	9		
		07/04/2019	9		
		07/05/2019	9		
		07/07/2019	5		
		07/08/2019	9		
		07/09/2019	9		
		07/10/2019	9		
		07/11/2019	9		
		07/12/2019	9		
		07/14/2019	5		
		07/15/2019	9		
Grand Total			109	12.00	1,308.00

Received Payment Mrs. $1,308.00 Signature of Provider

, Illinois

Therapeutic Day Care

Child	Case ID	Service Dates	Hours	Rate	Total
		07/16/2019	9		
		07/17/2019	9		
		07/18/2019	9		
		07/19/2019	9		
		07/21/2019	5		
		07/22/2019	9		
		07/23/2019	9		
		07/24/2019	9		
		07/25/2019	9		
		07/26/2019	9		
		07/28/2019	5		
		07/29/2019	9		
		07/30/2019	9		
		07/31/2019	9		
Grand Total			118	12.00	1,416.00

Received Payment Mrs. $1,416.00 Signature of Provider

APPENDIX B

OFFICE OF THE INSPECTOR GENERAL

Department of Children and Family Services

REDACTED REPORT

This report is being released by the Office of the Inspector General for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, identifying information has been changed. All names, except those of professional references, are fictitious.

File No: 2019-IG-2402

Child: Bella Castillo Esparza (DOB 11/2018; DOD 05/2019)

Subject: Child death

SUMMARY OF COMPLAINT

In May 2019, 6-month-old Bella Castillo Esparza was found unresponsive by her mother's paramour, who was caring for the infant and her 2½-year-old sibling while the mother was at work. The infant was reported to have been swaddled in a blanket and placed on her side on an adult bed with a bottle of formula in her mouth. Approximately 35 minutes later, she was discovered unresponsive on the bed in the same position she had been placed in. A household member contacted 911. CPR was performed, and the infant was transported to the hospital where she was pronounced deceased.

The Office of the Inspector General (OIG) investigated the death pursuant to its directive to investigate the deaths of Illinois children whose families have been involved with the Department of Children and Family Services (DCFS or the Department) within the preceding 12 months. There was a pending child protection investigation and a recently opened intact family services case involving the family at the time of Bella's death.

INVESTIGATION

Background

Bella (DOB 11/2018) was the second of three children born to her teen-aged mother, Davina Esparza (DOB 05/2000). Bella's biological father was reported to be Frank Castillo (DOB 07/1997). Davina gave birth to her eldest child, Gabriel Esparza (DOB 07/2016) at the age of 16. His father is unknown to the Department. At the time of Bella's death, Davina was three months pregnant with her third child, Hope Garcia (DOB 12/2019). Hope's biological father is Jeff Garcia (DOB 04/1999), with whom Davina and her two older children were living, prior to Bella's death.

Prior DCFS Involvement

Sequence A Investigation – Esparza, Davina – Reported 11/2018; Indicated 05/2019

In November 2018, following Bella's birth, it was reported to the DCFS Hotline that Davina and her baby girl tested positive for cocaine. An allegation of substance misuse by neglect (#65) was taken for investigation.

The next day, Child Protection Investigator (CPI) Kate Harper went to Acacia Hospital to meet the mandate. She interviewed the mother; and observed the infant. A hospital social worker confirmed that the infant and mother tested positive for cocaine and provided the CPI with the toxicology report. Davina denied using cocaine; she reported drinking alcohol socially and said that she may have had a drink laced with cocaine at a party but was unable to provide a time frame for the party. The investigator completed the substance abuse and domestic violence screens. Davina denied any domestic violence issues or substance abuse, but had tested positive for cocaine. She agreed to intact recovery program services[1] and to a safety plan upon discharge. Davina identified her mother, Leia Esparza (DOB 06/1985), for the safety plan. CPI Harper completed an UNSAFE CERAP, noting that the infant tested positive for cocaine at birth and that mother agreed to a safety plan upon discharge. The investigator documented in her contact note that she observed baby girl Esparza, and she appeared comfortable, bonding with the mother as she was being fed Similac.

CPI Megan Navarro[2] was assigned as the primary investigator three days later. That day, CPI Navarro met with the mother and maternal grandmother at the grandmother's home. According to her contact note,[3] CPI Navarro went over the terms of the safety plan with the mother and grandmother; they both agreed that the grandmother would be the safety plan holder for the children. CPI Navarro noted that the mother and grandmother both signed the plan and a copy was given to them.[4] CPI Navarro noted that she completed a home safety checklist[5] and observed the home to be clean and appropriate; there were two bedrooms, working utilities, heat and smoke detectors and a crib for the newborn. CPI Navarro also documented that the mother agreed to participate in intact family services.

There was no further documented activity from November 2018 until January 2019, when Supervisor Penny Olsen documented phone contact with CPI Navarro.[6] Her supervisory note reads:

> CPS to update all documentation of contact with child victims, perpetrator, reporter, and collaterals. Complete Intact referral and all assessments. CPS to have mother sign consent for DHS for herself and child victim. Referral to be submitted by 1/18/2019. Case to be submitted for closure by 1/25/2019. Extension requested.

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[1] The Intact Family Recovery Program is the collaboration between child welfare workers and alcohol and other drug abuse agency workers in serving mothers with prenatally exposed infants. This collaboration aims on improving services for substance affected families in child welfare and allows the engagement of mothers into treatment immediately after the birth of their child with the goal of keeping the family intact.
[2] CPI Navarro was an Option 7 - bilingual child protection investigator. She is no longer employed with the Department and was not interviewed for this report.
[3] This contact note was entered by CPI Navarro on 05/10/2019.
[4] A signed copy of the safety plan was not found in the attachments to the investigation.
[5] The Home Safety Checklist, which was an attachment to the investigation, was not signed by the parent, grandmother, or the investigator. Above the signature lines, the following was noted: "Completed per notes page 28 of 45." Page 28 of the investigation is the contact note created by CPI Navarro documenting her 11/2018 visit.
[6] Ms. Olsen was not the supervisor for CPI Navarro's team; she supervised CPI Navarro for approximately three months while the supervisor position for that team was vacant.

On February 8, 2019, Supervisor Olsen had phone contact with CPI Navarro, instructing her again to complete all notes and assessments and submit DHS consent and Public Health nurse referral.

Almost a month later, on March 6, 2019, Supervisor Olsen reviewed the still pending investigation with CPI Navarro and documented the following in her supervisory note:

> CPS said she tried to see the family on Saturday at MGM's [maternal grandmother] house as minors are under a safety plan and MGM was not home. MGM is not responding. The following tasks are required to ensure the minor's safety and to move toward a final finding and case closure: Case is being referred for Intact family services. CPS to submit referral with consents for release of information on minors. CPS to ensure that all case notes are up to date and all assessments are completed. CPS to submit referral by 03/08/2019.

Later that afternoon, on March 6, another investigator, CPI Rose Mendoza, observed Bella and Gabriel under the maternal grandmother's supervision. The investigator documented that the minors appeared well cared for with no signs of abuse or neglect.

On March 13, 2019, the case was submitted for an extension noting that the investigator still needed to submit the Intact Referral and all consents.

CPI Navarro documented a call with Davina on March 22, 2019 informing Davina that she was sending an intact referral form for intact family services. Davina again agreed to participate in intact family services; the investigator informed Davina that she would contact her next week for the transitional visit.

On April 12, 2019, Supervisor Sage Patel[7] documented in a supervisory note that another extension was needed.

On April 25, 2019, five months after the initial Hotline call, CPI Navarro spoke to the intact supervisor, Tina Lopez from Bravo Private Agency, by phone. CPI Navarro completed the handoff for the family case and discussed recommended services.

CPI Navarro along with the assigned intact worker, Veda Ramirez, from Bravo Private Agency completed the transitional visit with Davina on April 30, 2019. Recommended services that were discussed included: substance abuse assessment and treatment services, individual therapy, and parenting classes. Davina agreed to participate in intact family services. The investigator informed Davina that the recommendation was to indicate her for substance misuse by neglect. CPI Navarro documented that both children were observed with no signs of abuse or neglect. The investigator discussed safe sleeping with Davina. CPI Navarro completed a SAFE CERAP.

Supervisor Patel conducted a final supervision with CPI Navarro on May 9, 2019, and on May 11, 2019, Davina was indicated for substance misuse by neglect and the investigation was closed.

Supervision

In the five months that this child protection investigation was pending, CPI Navarro had three supervisors. In November, when CPI Navarro was assigned the investigation, Wendy Sharp was her supervisor; Ms. Sharp left shortly after and her team was divided amongst other supervisors at the Acme field office.

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[7] Supervisor Patel was on extended medical leave from December 2017 to March 2019 when she returned to work at the Acme field office; it was not until mid-April that she began to supervise her team, including CPI Navarro.

Supervisor Olsen supervised CPI Navarro for approximately three months while this investigation was pending until Supervisor Patel assumed the supervisory position for the team in mid-April.

Supervisors Olsen and Patel described high caseloads in the Acme field office. Supervisor Olsen stated that all investigators regularly carry 30-40 investigations. In addition, they both reported that the office is low on Spanish-speaking workers and as a result, the Option 7 bilingual investigators, like CPI Navarro, carry even higher caseloads.[8] Supervisor Olsen added that CPI Navarro worked on a Priority 1 team but also received Option 7 Priority 2 and 3 cases.[9] She said that this investigation was a Priority 2 case and as such, would have taken a back seat to any Priority 1 cases assigned to CPI Navarro.

Supervisor Olsen told OIG investigators that when she began supervising CPI Navarro, documentation in this investigation needed to be updated and the case still needed to be referred for intact family services. She could not remember whether the case was being referred for intact family recovery or for general intact services. She explained that referrals to intact family recovery require additional documentation, and all referrals are reviewed at three levels: supervisors, Area Administrators, and the intact gatekeeper. Supervisor Olsen acknowledged that several extensions were granted in the investigation because the referral for intact services had not been completed; however, she told OIG investigators that this is no longer considered a valid reason to grant an extension. She said extensions must be approved by the supervisor and the Area Administrator. Supervisor Olsen also acknowledged that a safety plan with the maternal grandmother existed in this case, which would have required the investigator to go out every five working days to monitor; she said that based on documentation, CPI Navarro did not do so in this case. Supervisor Olsen described CPI Navarro as "fairly experienced." She told OIG investigators that she met with CPI Navarro at least monthly. She said CPI Navarro always met her mandates and regularly communicated about her cases, however, she did not complete all tasks.

Supervisor Patel told OIG investigators that she started supervising CPI Navarro in mid-April 2019. She said she worked with CPI Navarro to close out her cases as she was preparing to leave DCFS and said the Area Administrator approved taking CPI Navarro off intake in April. Supervisor Patel explained that CPI Navarro worked a four-day week (Wednesday-Saturday) and she only supervised her for approximately 15 days. She also described CPI Navarro as hard working.

Intact Family Services case with Bravo Private Agency

An intact family services case was open for approximately one month before Bella died in May 2019. The case was opened to Bravo Private Agency, assigned to Caseworker Ramirez, who was to be supervised by Ms. Lopez.[10] At the time of case opening, Davina resided with her paramour Jeff, his mother Yara Garcia (DOB 10/1981), Yara's paramour, Zack Taylor (DOB 03/1982) and their son, Zack Taylor Jr. (DOB 10/2008).[11] Davina and Jeff had been dating for four to six months per different reports.

The transitional visit occurred on April 30, at which time CPI Navarro terminated the safety plan. The intact worker told OIG investigators that the transitional visit, as well as all other visits, occurred at Yara's home. Davina, her two children, and Yara were the only household members present at the transitional visit. The

[8] OIG investigators reviewed the DCFS Protective Service Teams By Worker Report for the months of October 2018 to June 2019, which confirmed CPI Navarro carried a high caseload.
[9] Supervisor Patel explained that serious harm and death cases are considered Priority 1 cases; less serious allegations are Priority 2; and Norman fund issues are Priority 3.
[10] Shortly after the intact case opened, Supervisor Lopez left the country due to a family emergency, and Ms. Ramirez was supervised by the private agency director.
[11] It was later reported that Mr. Taylor only lived in the home for a couple of months while he was waiting for an apartment to come through and moved out in June 2019.

intact worker completed a home safety checklist, documenting that she found the home to be clean, well furnished, and organized, with appropriate sleeping arrangements for minors; she observed the children to be happy and well-groomed. In her OIG interview, Ms. Ramirez said the home had three bedrooms, one of which Davina, her two children, and Jeff shared; Gabriel had a toddler bed and she provided the family with a playpen for Bella. Service recommendations for Davina included: parenting classes, individual counseling, substance abuse assessment and treatment. The intact worker informed Davina that she would be conducting weekly announced and unannounced visits.

Ms. Ramirez conducted three more home visits prior to Bella's death. On the evening of May 7, 2019, Ms. Ramirez conducted an announced visit to the home. According to her contact note, the worker observed both minors and noted that the children, Bella, and Gabriel, appeared to be happy and well groomed. No unusual cuts, bruises, or marks were observed on Bella. A bruise was observed on the left side of Gabriel's face around the eye. Davina stated that this was the bruise that she told the worker about the previous day when Gabriel fell down the stairs.[12] Davina reported to worker that she took Gabriel to the doctor that morning and showed the worker the doctor's note; the worker instructed Davina to show the doctor's note to Gabriel's daycare provider.[13] The home was observed to be clean and safe with functioning utilities and a smoke detector. Ms. Ramirez discussed intact services with Davina and completed an integrated assessment.[14] The worker stated that she would be referring Davina to Condor Systems for substance abuse services and to Daffodil Services for parenting classes to begin in July.

The intact worker documented another visit to the home on May 13, 2019 at 6:45pm.[15] after a Hotline report was made by an individual regarding Gabriel. For more detail, see *Sequence B Investigation* below. In her contact note, Ms. Ramirez noted that she observed no unusual cuts, marks, or bruises on Bella; a burn-like injury was observed on Gabriel's forehead. Davina reported that the injury occurred because she put Gabriel in the corner for a timeout and Gabriel began to hit his head against the wall. Davina reported she took Gabriel to the doctor after the injury occurred and showed the worker a doctor's note.[16] The worker and Davina discussed the Hotline call. Davina reported that an investigator had been to the home following the Hotline call. During the worker's visit, a detective from the Juno Police Department came to the home to speak with Davina. While Davina spoke with the detective, the intact worker spoke to Jeff's mother, who reported that Gabriel hurt himself on the wall. Ms. Ramirez told OIG investigators that she first learned of the subsequent Hotline report through a SACWIS alert and reported having phone contact with the child protection investigator assigned to the B sequence.

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[12] Ms. Ramirez told OIG investigators that Davina had texted her about the fall the day before her home visit.

[13] Gabriel was taken by Davina to Bluebill Medical Center to see Dr. Aldo Valdez the morning of May 7, 2019. Records note that he was there for bruising on the face. As per Davina, Gabriel fell down the stairs on May 6, 2019 as they were walking up to their apartment. Gabriel fell face down and landed on the side of his face. Dr. Valdez believed the story was consistent, the child had no other bruises, and Dr. Valdez had no concerns of abuse or neglect.

[14] The integrated assessment did not include Jeff.

[15] The contact date/time is documented as 5/13/19 6:45pm. at the top of the contact note, however, in the body of the note, the worker wrote that an announced visit was conducted on May 7, 2019 at 6:00pm. During her OIG interview, Ms. Ramirez acknowledged her mistake and confirmed that the date of the visit was in fact May 13.

[16] Gabriel was seen at Egret Hospital ER on May 13, 2019 at 10:33am for a forehead abrasion. According to the medical records, the patient presented with an abrasion across his forehead, his mother stated the patient was banging his head on the wall last night. This occurred after he was placed in timeout. The mother expressed behavioral concerns and stated that she discussed this with Dr. Valdez and was awaiting a referral for ADHD screening. The wound was cleaned up in the ER and a simple dressing was applied. The ER doctor called the primary care physician, Dr. Valdez, and the doctor confirmed that he made a referral for behavioral services and evaluation for ADHD. The patient had a bandage placed on the wound and was given bacitracin ointment. It does not appear that a full body exam was conducted at the ER visit; however, the medical records do note "a back exam included findings of normal inspection."

On May 17, 2019, Ms. Ramirez went to Weisel Daycare to pick up observation reports for Gabriel and to speak with employees. The teachers told the intact worker that they observed the burn-like injury on Gabriel's forehead and were concerned because of the number of injuries he was receiving. They also expressed concern about the safety of the children when Jeff picked them up from daycare due to his gang affiliation and the daycare center not being in his gang's territory. The teachers informed the intact worker that Davina reported to them that she was two months pregnant.

The intact worker's third and last visit to the home occurred five days prior to Bella's death. According to her contact note, Ms. Ramirez conducted an announced visit at 6:30pm. She observed both minors; Bella was being fed by Jeff and Gabriel was on the couch watching television. The worker discussed service recommendations with Davina. She advised Davina that she made an appointment for her to have a substance abuse assessment at Condor Systems in eight days at 10:30am and reminded her that parenting classes would begin in July. Ms. Ramirez told OIG investigators that her first time meeting Jeff was at this home visit after she asked Davina to have him present.

On the following day, the intact worker went to Weisel Daycare following an incident in which Jeff was attacked while walking back from the daycare with Davina and the two kids. The teachers shared a video of the incident taken by another parent and told the intact worker that it would be best for the worker to assist Davina in finding alternative daycare as they did not believe it was safe for Jeff to come around the daycare anymore.

Ms. Ramirez told OIG investigators that Jeff was not part of the case initially because he was not identified as part of the family composition by the DCP investigator, but said they were in the process of adding him to the family's case prior to Bella's death. Jeff was added to the family composition and interviewed for the integrated assessment on June 4, 2019. Jeff was on house arrest for unlawful possession of a weapon; Ms. Ramirez reported communicating with his probation officer through email.

Sequence B Investigation – Esparza, Davina – Reported 05/13/2019; Unfounded 07/25/2019

The intact case had been open for approximately two weeks when there was a Hotline call involving the family on May 13, 2019 at 2:22pm. The narrative reads in part:

> ***EMERGENCY – Young child with a substantial burn to the face that requires medical attention***
>
> Gabriel (age 2) presented today (05/13/19)… with what appears to be a large burn-like injury on his forehead. He is missing skin on his forehead to his hairline. Davina was informed to take Gabriel to the ER but it is unknown if she did or not... In the last two months, Gabriel has been seen with several injuries on several different occasions. He has had old faded bruises on his temples, marks" on his face and hands, a cut to his lip, and what looks like self-inflicted bite marks before. Reporter did not see Gabriel for about a week in the month of May and he showed back up with marks on his face and significant swelling. It looked like the injuries had been healing for a time. Davina (Mother) stated Gabriel had fallen in the park but Jeff (Father) gave a different story. Gabriel said his mom hurt him and pointed to his face and said "owie." Reporter has pictures and videos of the injuries. Gabriel demonstrates what may be reactive behavior to abuse; he yells, spits, and can be "rough" with adults and other children and self-inflicts bites upon himself. Jeff is GANG-affiliated and has tattoos of pitch forks on his fingers. Domestic violence is suspected between the parents.

Allegations of burns by abuse (#5) and cuts, bruises, and welts (#11) to Gabriel by Davina and Jeff were taken for investigation. This investigation was pending at the time of Bella's death.

Bree Walsh was the assigned child protection investigator. CPI Walsh told OIG investigators that she had been an investigator at the Acme field office for three-and-a-half years, and in that time she had five supervisors. When this investigation was assigned, Sage Patel was her supervisor.[17]

On May 13, CPI Walsh contacted the Caseworker Ramirez by phone to inform her of the Hotline report. According to her contact note, Ms. Ramirez knew of the report and planned to see the family that evening; she stated Davina was at the doctor and would not be home until after 6:00. The intact worker told the investigator that she did not have any concerns about Davina. She stated they recently opened this case for intact services and the mother was about to start parenting classes. CPI Walsh asked about drug history, and the worker said that although the case came in for substance misuse, she did not have any current concerns about that. The worker told the investigator that Davina was residing with her boyfriend and his mother, but the boyfriend was not the father of the children. Also, that day, CPI Walsh received a phone call from a detective, informing her that he was assigned to the case and would be going to the home later that night.[18]

The investigator went to the home that evening and observed the children and interviewed Davina.[19] According to her contact note, Gabriel was asleep; Davina did take the bandage off his forehead so that the investigator could see the mark. Bella was observed with no marks or bruises. Davina said she did not understand why the investigator was there because she already had a worker. CPI Walsh explained she had a new investigation for allegations of abuse to her son. Davina stated that she had just come home from Egret Hospital with him.[20] She stated that her son hit his own head on the wall. She stated that she had him in timeout and that he started having a tantrum. Davina said he hit his head twice in a row and she told him to stop. She said he stopped but started again. She then moved him from the wall. Davina stated he was not bleeding but his forehead was red. She said when she took him to the daycare, they told her he had to be seen by a doctor before returning. Davina stated that her son has been having behaviors like that where he would bite himself, hit his head, and fall out on the floor. She stated that she was having him evaluated for ADHD. Davina stated that she lives with her boyfriend, but he is not the father of her children. She stated that she has been dating him for about four months and she did not have anywhere else to go. Davina stated that her intact worker was getting her into parenting classes. She stated that she works full time and her children go to daycare during that time, and she picks them up when she gets off. She stated that she uses timeout for her son. Jeff was not interviewed as he was not at the home at time of the visit per contact note.[21] The investigator documented that she observed the apartment with working utilities and no obvious hazards. CPI Walsh also spoke with Yara, who reported that Davina had been staying in her home for about two months. Yara's plan was to help Davina get on track and find her own place. She reported she felt sorry for Davina being so young with two children. She stated that she felt Davina was a good mother; she was just young and could use more guidance. She denied that she had seen any drug or alcohol issues with Davina. Yara stated that she was at work when the incident occurred and heard about the bruise on Gabriel's forehead when she came home. She said she told Davina that she needed to take him to the doctor first thing in the morning. CPI Walsh completed a SAFE CERAP noting: "The mother took child to the doctor

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[17] In July 2019, CPI Walsh transferred to the Balsa field office and took this investigation with her; Supervisor Camila Zamora approved the final CERAP and finding in this investigation.

[18] In her OIG interview, CPI Walsh explained that a detective from the Juno Police Department was assigned because this was a Priority 1 case. She said in Juno, Priority 1 cases are automatically referred to the Police Department.

[19] The assigned detective and intact worker also went to the home later that night to assess the minor.

[20] Gabriel was assessed at Egret Hospital ER on May 13, 2019 at 10:33am for a forehead abrasion. A photo of the discharge document was uploaded to SACWIS.

[21] According to CPI Walsh's interview with OIG, when the detective went to the home, Jeff was home and gave the same story, and Gabriel was awake.

as requested. Intact family services is monitoring the children on a weekly basis. The agency stated they had no concerns about the family. The home appeared safe and appropriate. The doctor reported that the burn is an abrasion and not a burn."

In May 2019, while the B sequence was pending, Bella's death was reported to the Hotline (For more detail, see below *Death, Sequence C Investigation*).[22] According to a supervisory note, Supervisor Patel notified CPI Walsh of the death and instructed her, amongst other things, to request a second opinion from MPEEC to confirm the injury to Gabriel was an abrasion and not a burn.[23] To address the case, MPEEC was given a photo of the child's head, CANTS report, ER visit report, and six pages of SACWIS notes for review. The MPEEC report concluded:[24]

> In summary the lesion to his head is a sentinel injury, it is a gateway to DCFS to assess the child's ongoing risk. With regard to the skin injury it is an abrasion not a burn and there are concerns for delay in care; reviewing the photo the mother should have gone to seek care. The lesion is nonspecific and it can be consistent with abrasion against a surface.

A final supervisory note written by Ms. Zamora on July 24, 2019 reads in part:

> PSA HAS CONDUCTED FINAL REVIEW OF THIS INVESTIGATION; RECOMMENDED FINDING IS UNFOUNDED, AS THERE IS NO CREDIBLE EVIDENCE TO SUBSTANTIATE CHILD VICTIM HAD A BURN; CHILD VICTIM HAD AN ABRASION, WHICH WAS CAUSED TO HITTING HIS HEAD AGAINST THE WALL WHILE IN TIME OUT; THERE IS NO EVIDENCE CHILD VICTIM SUSTAINED CUTS, WELTS, BRUISES OR ORAL ABRASIONS AS A RESULT OF THE ALLEGED PERPETRATOR'S ACTIONS. MOTHER IMMEDIATELY SOUGHT MEDICAL CARE FOR CHILD VICTIM UPON BEING NOTIFIED CHILD HAD AN INJURY.

On July 25, 2019, the report was unfounded.[25] The rationale was that the child did not have a burn, and the mother sought medical care for the abrasion. The mother put the child in time out and the child began bumping his head against the wall. The mother did not remove him from the wall immediately, but eventually moved him away from the wall. The mother sought medical care once she was instructed to by the daycare.

<u>Death & Current DCFS Involvement</u>

Sequence C Investigation – Esparza, Davina – Reported 05/2019; Indicated 09/2019

In May 2019, less than two weeks from when the B sequence investigation was initiated Bella's death was reported to the DCFS Hotline. The narrative reads in part:

> At an unknown time on 5/2019, Davina (mother) left for work, leaving Bella (6 months) and Gabriel (2) in the care of Jeff (paramour). Jeff reportedly swaddled Bella in a blanket and began feeding the child. After Bella fell asleep, Jeff laid Bella on a bed. Bella was laid

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[22] CPI Walsh was the primary assigned investigator for the C sequence also.
[23] The Department requested the consult because they wanted to ensure that they were not missing anything following the unexpected death of the 6-month-old sibling, while this investigation was pending.
[24] The MPEEC report dated June 27, 2019 is part of the attachments to the investigation.
[25] Temporary custody of Gabriel was granted to the Department two days prior to the B sequence investigation closing due to information learned during the subsequent investigation (Sequence C).

> on her side, and Jeff left the bottle in Bella's mouth. It was reported that Jeff then tended to Gabriel, leaving Bella unattended for approximately 15 to 20 minutes. Jeff then found Bella unresponsive, and Yara (Jeff's mother) attempted CPR while 911 was contacted at 12:16pm. Bella was transported to Acacia Hospital via Ambulance 69, and the doctor pronounced Bella deceased at 1:00pm.

An allegation of #51- death by neglect to Bella by Jeff was taken for investigation.

CPI Daria Bohr met the mandate and went to the home that evening. She interviewed Davina and Jeff and observed Gabriel. Davina stated that Bella woke up at 6:00 that morning and was cooing and playing with her hands and feet. She reported caring for the infant while Jeff and Gabriel remained asleep. She reported feeding the infant between 6:30-7:00am.; the infant consumed 8 oz of Similac. Davina reported that she woke Jeff up at approximately 9:00am. She was scheduled to work at 10:30am. She said she received a call from Jeff at approximately 12:00pm. telling her to come home because the baby had stopped breathing. Davina reported that she was currently three months pregnant with her third child; Jeff was the father of her unborn child. She said she was getting prenatal care and her due date was in December. Davina told the investigator that she and Jeff had been dating for six months. She said Jeff had been around Bella since she was a month old and she did not believe he harmed her.

Jeff reported that Bella became fussy; he made her an 8 oz bottle, swaddled her in a pink infant blanket and started feeding her while he was holding her. He said she fell asleep after consuming one ounce of formula. He lay her down on top of a blue blanket, tilted her on her right side, and propped the bottle in her mouth. Jeff then went to take care of 2-year-old Gabriel. When Jeff walked back into the bedroom to check on Bella 10-15 minutes later, he found her cold to the touch and unresponsive. He picked her up and brought her to his mother, who started CPR while Jeff called 911.

The investigator observed Gabriel to have a healed abrasion on his forehead, healing bruise/bitemark on forearm and unexplained bruising to his chest.[26] CPI Bohr completed an UNSAFE CERAP. Davina agreed to a safety plan that Gabriel would live with his maternal great grandparents, while the C sequence was investigated; Davina and Jeff would have no unsupervised contact.

CPI Walsh documented that she observed Gabriel at his maternal great grandmother's home three days later. The child had visible marks on his body and was taken to his primary care physician by his caretaker. On June 6, the investigator spoke with the primary care physician who confirmed that he saw the child again and the marks on his body are consistent with being hit with something like a belt, but could not be certain what the child was hit with. He reported the bone on his chest that sticks out is consistent with his body's development. The physician said he would send the child for an x-ray and stated he did blood work with no noted concerns.

In July 2019, CPI Walsh completed a SAFE CERAP noting: "TC was granted on today and child is placed with his maternal great grandmother." The family case was transferred to Foxglove Placement Services after the Department took custody of Gabriel, as it was no longer an intact family services case.

Following a formal investigation, on September 21, 2019, Jeff was unfounded for death by neglect (#51) but indicated for an allegation inadequate supervision (#74). The rationale was that the cause and manner of death was ruled undetermined on autopsy; the paramour went to tend to another child and left the child drinking a bottle, and upon his return 15-20 minutes later he found the child unresponsive. Davina was indicated for cuts, bruises, and welts (#11) to Gabriel.

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[26] The injuries were documented on a body chart and photographs of the injuries were uploaded to SACWIS.

Sequence D Investigation– Esparza, Davina – Reported 12/2019; Indicated 01/23/2020

In December 2019, it was reported to the DCFS Hotline that Davina delivered a baby girl with no complications. The reporter said the child was negative for substances. Davina has given birth to two previous children; one child is in custody and one passed away in May 2019. The reporter said Davina had an open DCFS case with Foxglove Placement Services. Davina was investigated and indicated for an allegation of substantial risk of physical injury/environment injurious by neglect (#60) to the newborn baby (Sequence D Investigation). About one week later, protective custody was taken of newborn Hope and temporary custody was granted.

Hope is in a traditional placement. Gabriel remains in his relative placement. The parents are engaged in services.

Intact Family Services Referral Process

Child protection investigators, in consultation with their immediate supervisor, make the decision to refer a family for intact services. If the family agrees to accept services, the investigator must complete all case opening activities in accordance with Procedures 302, Appendix R, *Case Opening Protocol*, which includes up-to-date documentation of all investigative activities. According to Procedures 302, the investigator and/or supervisor begins the process by submitting a fully and comprehensively completed CFS 2040, Intact Family Services Case Referral and Assignment Form. The Child Protection Supervisor then forwards the CFS 2040 to the Area Administrator for approval (See Procedures 302.388). Referrals for general intact family services are sent to a general DCFS Intact mailbox and referrals for the intact family recovery program are sent directly to the Intact Family Recovery Program Manager for case assignment.

The Program Manager explained to OIG investigators that Intact Family Recovery (IFR) is an intensive program primarily for indicated substance exposed infant (#65) allegations. She said on occasion an IFR case also can be opened for an indicated allegation of substantial risk of physical injury/environment injurious (#60). The IFR program joins child welfare with alcohol and other drug (AOD) abuse treatment in a team effort to provide comprehensive services to intact families during the recovery process. The voluntary program is designed to last 18 to 24 months, longer than regular intact. The Program Manager told OIG investigators that the Department contracts with specific providers to provide IFR services to certain regions in Illinois. The Program Manager is the "gatekeeper." She reviews every referral for IFR and if appropriate, assigns the case to the appropriate provider. Additional documentation is required for IFR referrals. The Program Manager provided OIG investigators with the following Intact Family Recovery Program Referral Checklist:

Intact Family Recovery Program Referral Checklist

- **Data Sheet**
- **1425 Change of Status**
- **CFS 2040 Intact Family Referral/Assignment form**
- **Substance Affected Families Protocol (CFS 440-11)**
- **Home Safety Checklist (CFS 2027)**
- **CANTS 18-DV**
- **CANTS 18 –Paramour**
- **Public Health Referral**
- **CFS 440-5Adult Substance Abuse Screen**
- **CERAP**
- **CA/N Investigation contact notes**

- **Visual assessment of newborn's living environment**
- **SEI's birth information i.e., weight, gestation, special needs etc.**
- **Assessment of other minors in the home**
- **Prior sequences review (if applicable)**
- **Risk Assessment Summary**
- **Burgos language determination form (if applicable)**
- **CANTS & LEADS**

In addition, the Program Manager requests that the investigator document a conversation with the parent(s) that they are willing and agreeable to do intensive family services that can last 18 – 24 months and provide them with the IFR brochure. She also asks that the investigator obtain any medical/toxicology/meconium cord reports.

The Program Manager told OIG investigators that upon receiving an incomplete packet, she emails child protection, identifying missing documentation and/or needed corrections. She said the purpose of all of the forms is to share information with the POS counterparts; DCP is supposed to link services for families, and she said it is extremely difficult to get the information from the investigator once they have moved on and the investigation has been closed. The Program Manager said she has been told that she is "too strict or picky" with the information she requires during the referral process.

ANALYSIS

The Department first became involved with 18-year-old Davina in November 2018 after she gave birth to her second child, a substance exposed infant. The investigator meeting the 24-hour mandate immediately identified this case as appropriate for the IFR, an intensive program meant to facilitate the engagement of mothers into treatment immediately after the birth of a substance exposed infant with the goal of keeping the family intact. Although she denied substance misuse, Davina agreed to participate, and agreed to a safety plan until the referral was completed. By all accounts, this should have set the stage for a seamless transition from investigation to intact services for the teenaged mother of two. Instead, it took five months for a referral to occur and for a regular intact family case finally to be opened in May 2019.

The lack of action by a single investigator held up a process and ultimately services for this family for five months, and the Department missed the opportunity to provide immediate intervention to this young mother. Despite the fact that the case was appropriately identified for IFR services two days after the Hotline call in November 2018, and Davina agreed to those services, a referral was not completed until April 2019. In January 2019, after no documented activity for almost two months, a supervisor instructed CPI Navarro to complete notes and referrals and requested an extension. The same supervisor repeated those instructions in February and March 2019 and requested another extension due to the investigator not completing the tasks. In April 2019, another supervisor requested a third extension as the family still had not been referred for intact services. When a referral did occur, it was for general intact family services and not for IFR. There was no indication that the investigator attempted to refer to the IFR program first, or that there was a new assessment of the family's needs that led to the decision to refer the family for traditional intact family services. A referral to regular intact services five months later gives the appearance of a lack of urgency on the part of the Department.

Mirroring the investigator's lack of documentation and timely referral for services, CPI Navarro did not ensure the safety of the children, who had been in a safety plan with the maternal grandmother since the beginning of the investigation. Rules and Procedures require weekly monitoring of safety plans; CPI Navarro saw the children two times in the five months that the investigation remained pending, once in

November 2018, at her initial visit and again on April 30 at the transitional visit. Had intact services been involved sooner, they could have served this critical function of monitoring the safety of the children.

The Department's response to improve the timeliness of referrals was to stop granting extensions solely to allow these referrals for intact to be completed. This response falls short and potentially creates other issues by forcing investigations to close prior to referrals being completed and prior to the sharing of necessary information with the POS agencies charged with servicing these families.

Intact family services serve a critical function with families in which risks have been identified but children remain in the home. Accurate identification of service needs and timely case openings enables the Department to assist those families and decrease child safety concerns. The Department cannot allow the referral process to be a barrier to families getting services. While there were issues specific to this case which may have contributed to the delay (an investigator who was preparing to leave the Department and multiple supervisors), the repeated instructions and extensions suggest that the process is too reliant on a single actor/individual and that ineffective monitoring or enforcement of referrals is also a problem. For an investigator dealing with high caseloads, tasks can be burdensome and although supervisors can assist with those tasks, more often than not, many leave it to the investigators to complete.

At the Governor's request, Chapin Hall performed an analysis of challenges facing the Intact Family Services program. The report, released May 15, 2019, reviewed systemic issues and made nine recommendations for short-term and long-term changes that amongst other things included improvement in processes and led to two recent policy guides (2020.90 and 2020.10).[27] In accordance with the Chapin Hall report, the Department must assess the intact family referral process and create a mechanism to ensure referrals are made in a timely manner. In its assessment, the Department should determine whether there is a need to create a more efficient referral system.

RECOMMENDATIONS

1. The Department should review the referral process for Intact Family Services. As this case demonstrates, the timeliness of referrals is an issue and the referral process is not adequately monitored or enforced. The Department's review of the referral process should address streamlining the process by deleting duplicative or unnecessary steps, delineating a clear path of administrative review to ensure timely referrals, and assessing barriers to referrals.

2. The Intact Family Recovery coordinator should conduct a training for the region child protection investigation supervisors and area administrators to ensure the field is educated about the program and the referral process. If the program regularly has openings, the coordinator should, through email or an announcement, inform supervisors of the openings.

[27] Weiner, D., & Cull, M. (2019) *Systemic review of critical incidents in intact family services.* Chicago, IL: Chapin Hall at the University of Chicago.